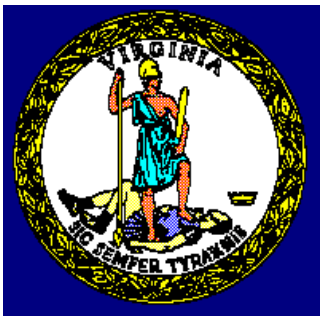

Commonwealth of Virginia
Department of Medical Assistance Services

2015 External Quality Review Technical Report

March 2016

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ACKNOWLEDGMENTS AND COPYRIGHTS

1. Executive Summary

Introduction

The Virginia Department of Medical Assistance Services (DMAS) is the single state agency that administers the Medicaid managed care program in the Commonwealth of Virginia (Virginia). As of December 2015, DMAS contracted with six managed care organizations (MCOs) to deliver services to over 749,000 children in low income families; aged, blind, or disabled individuals; pregnant women; and certain caretaker parents in Virginia. Contracted MCOs included Anthem HealthKeepers Plus (Anthem), CoventryCares of Virginia (Coventry), INTotal Health (INTotal), Kaiser Permanente, Optima Family Care (Optima), and Virginia Premier Health Plan, Inc. (VA Premier).

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires states that operate Medicaid managed care plans to "provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract." Federal external quality review (EQR) requirements have been further specified in 42 Code of Federal Regulations (CFR) §438.358 and §438.364.

DMAS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct EQR activities and produce this technical report covering review activities completed during the period of January 1, 2015, through December 31, 2015.

Purpose of the Report

The 2015 EQR Technical Report was developed to meet the review and reporting requirements mandated by the SSA, codified in the CFR, and further defined by the Centers for Medicare & Medicaid Services (CMS). This 2015 EQR Technical Report includes a review of the quality outcomes and access to and timeliness of care and services provided to Medicaid managed care members in Virginia.

The EQR of the MCOs included the two federally mandated activities as set forth in 42 CFR §438.358, annual validation of performance measures, and annual validation of performance improvement projects (PIPs). The third federally mandated review activity, review and evaluation of compliance with federal managed care standards and associated State contract requirements, is required to be conducted every three years. Since this was last conducted in 2014 and addressed in the 2014 EQR report, corrective actions taken by the MCOs as a result of the prior year review are included in this 2015 report.

In addition, a number of other activities and results are addressed in this report:

- Results of select Healthcare Effectiveness Data and Information Set (HEDIS) measures and review of NCQA HEDIS Compliance Audits.

- Results of *Diabetes Long-Term Complications Admissions Rate* (Prevention Quality Indicator [PQI] #3) aggregate measure.
- Activities related to three clinical focused studies: Improving Birth Outcomes through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Health Acute Population.
- Activities related to encounter data validation (EDV).
- Results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for both the Medallion 3.0 and Family Access to Medical Insurance Security (FAMIS) Plan populations, including General Child and Children with Chronic Conditions.
- Technical assistance activities related to the Consumer Decision Support Tool.
- Description of best and emerging practices implemented by the MCOs for improving quality of care and service.

Overview of External Quality Review

The 2015 EQR Technical Report focuses on a number of distinct EQR and DMAS review and monitoring activities conducted from January 1 through December 31, 2015. As shown in Table 1-1, the activities were conducted to assess the domains of quality of, access to, and/or timeliness of care and services.

Table 1-1—EQR and DMAS Activities and Domains

Activity	Quality	Access	Timeliness
NCQA HEDIS Compliance Audit and Rate Review	✓	✓	–
Performance Measure Validation	✓	✓	✓
PIP Validation	✓	✓	✓
Clinical Focused Study Results	✓	✓	✓
Encounter Data Validation Activity	✓	✓	–
Consumer Satisfaction (CAHPS) Review	✓	✓	✓

NCQA HEDIS Compliance Audit, Performance Measure Validation, and Rate Review

HSAG reviewed five MCOs' HEDIS final audit reports (FARs), Information Systems (IS) compliance tools, and interactive data submission system (IDSS) files to assess adherence to seven IS standards. Kaiser Permanente was not included in the review, having not submitted 2014 HEDIS rates to NCQA because it was not a contracted MCO until 2013. In general, the MCOs' information systems and processes were compliant with the applicable NCQA IS standards and the HEDIS reporting requirements related to key quality measures.

In addition, DMAS contracted with HSAG to validate performance measures to assess the accuracy of measure rates reported by the MCOs and to determine the extent to which performance measure

calculation followed state specifications and reporting requirements. Three HEDIS measure rates were validated for the five MCOs: *Adolescent Well-Care Visits*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*. HSAG's performance measure validation (PMV) activities resulted in corrections to *Adolescent Well-Care Visits* rates for Coventry (decreased by 1.21 percentage points), INTotal (decreased by 2.46 percentage points), Optima (decreased by 1.85 percentage points), and VA Premier (decreased by 0.22 percentage points). All other rates were deemed accurate as reported.

MCOs varied in their key HEDIS performance measure results. Most of the MCOs reported positive performance in the area of Children's Preventive Care, with three of the five MCOs' rates at or above the Quality Compass 50th percentiles for the following measures:

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 2*
- *Lead Screening in Children*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

However, measure rates for *Childhood Immunization Status—Combination 3* demonstrated an opportunity for improvement for all MCOs.

Three of the five MCOs also demonstrated positive performance in the Women's Health measure set, with rates that met or exceeded the Quality Compass 50th percentiles for these measures:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*

Conversely, the remaining two MCOs' rates were well below the Quality Compass 50th percentiles for these measure indicators. Further, *Breast Cancer Screening* measure rates indicated opportunity for improvement for all five MCOs.

Within the Care for Chronic Conditions measure set, documentation of controlling and testing hemoglobin A1c (HbA1c) levels for members with diabetes was an area of strength. However, low measure rates for the *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* and *CDC—Blood Pressure Control (<140/90 mm Hg)* measure indicators demonstrated a need for improvement. Additionally, four of the five MCOs' performance indicated opportunities to improve rates for the *Use of Appropriate Medications for People with Asthma—Total* measure indicator.

Measures in the Behavioral Health measure set showed the most opportunity for improvement for a majority of the MCOs. Specifically, four of the five MCOs' rates were low for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicators. Further, rates for three of the five MCOs were low for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure indicators.

HSAG recommends that DMAS continue collaborating with the MCOs to increase performance rates, with the goal of meeting or exceeding the Quality Compass 50th percentile. In addition, given the variation in MCO HEDIS rates within each measure set, HSAG recommends that DMAS facilitate sharing of successful improvement interventions for HEDIS measure rates between MCOs. Lastly, HSAG recommends that MCOs focus on key HEDIS measures falling well below the Quality Compass 50th percentiles using a small-scale, rapid-cycle intervention testing to assess effectiveness and facilitate spread of successful initiatives.

PIP Validation

PIPs provide a structured method to assess and improve processes and outcomes for care provided to MCO members. PIPs are validated to determine compliance with the requirements of 42 CFR §438.240(b)(1) and 42 CFR §438.240(d)(1–4). DMAS required each of the MCOs to conduct two PIPs during 2015 related to two priority HEDIS measures, *Follow-Up After Hospitalization for Mental Illness* and *Adolescent Well-Care Visits*.

HSAG validated the performance of each MCO on three stages of the PIP process: Design, Implementation, and Outcomes. Kaiser Permanente was not required to conduct PIPs in 2015. Four of the five MCOs scored 100 percent (met all applicable evaluation elements) in the Design stage. Optima scored 96 percent in the Design stage. Four of the five MCOs also scored 100 percent in the Implementation stage. Optima scored 69 percent compliance in Implementation. Outcomes measure scores ranged from 67 percent (Anthem) to 33 percent (INTotal).

Because the Outcomes stage is the culmination of the previous two stages of the PIP, substandard Outcomes scores indicate the need to revisit the Design and Implementation stages. Overall, HSAG recommends a focus on active interventions with routine evaluation of impact of the interventions. To improve outcomes, rapid-cycle testing of small-scale interventions, using the Plan-Do-Study-Act (PDSA) cycle, is being implemented as part of the 2016 PIP methodology.

Focused Studies

DMAS contracted with HSAG to conduct three clinical focused studies. The Improving Birth Outcomes Through Adequate Prenatal Care study is currently in progress, and final results will be provided to DMAS in March 2016. This study is designed to answer two questions:

- *To what extent do women with births paid by Medicaid receive early and adequate prenatal care?*
- *What clinical outcomes are associated with Medicaid-paid births?*

Five related study indicators will be calculated and results will be stratified by study and comparison groups, Medicaid program, Medicaid delivery system, and demographic categories.

The Improving the Health of Children in Foster Care study is also currently in progress, and final results will be available to DMAS in September 2016. This study is designed to answer the question:

To what extent did children in foster care receive the expected preventive and therapeutic medical care in the first year of managed care service delivery?

Administrative and medical record data will be used to calculate 15 study indicators across three categories (characteristics of Medicaid members in foster care, preventive care, and behavioral health).

HSAG worked with DMAS to develop a Health and Acute Care Program focused study that will provide quantitative information about the clinical profile of Medicaid Medallion 3.0 members in the Health and Acute Care Program (HAP). Beginning on December 1, 2014, the service delivery system for members covered by one of five waiver programs was unified under managed care in HAP. The study will address the following question: *To what extent did HAP members in this combined waiver population use medical and pharmacy services during the first year of managed care coverage?*

Results of these studies will be used to improve prenatal care and birth outcomes among Medicaid members, appropriate use of preventive and therapeutic care among foster care children in the Medicaid population, and use of medical and pharmacy services for the waiver population.

Encounter Data Validation

For the 2015–2016 contract year, DMAS contracted with HSAG to conduct an EDV study to assist DMAS in developing an encounter data program that effectively monitors the accuracy and completeness of encounter data submitted by the MCOs. HSAG conducted a review of current encounter data protocols and procedures for submission, collection, processing, management, and monitoring of encounter data, including discussions with DMAS staff members to target priority areas for improvement. HSAG provided technical assistance (TA) related to monitoring and reporting strategies, and performed an assessment of encounter data accuracy, completeness, and timeliness. HSAG is scheduled to submit one aggregate report with key findings and recommendations to DMAS on or before January 31, 2016.

Consumer Survey of Quality of Care

The CAHPS survey is nationally recognized as the industry standard for evaluation of members' experiences with the health care and services they have received.

DMAS contracted with HSAG to administer the CAHPS 5.0 Child Survey with the Children with Chronic Conditions measurement set for the statewide FAMIS program. The response rate was 32.0 percent, which was greater than the national child Medicaid rate of 28.5 percent. For the general child survey, the FAMIS program scored 67.4 percent for *Rating of All Health Care*, which was above the NCQA national child Medicaid average. The FAMIS program scored more than 5 percentage points below the national child Medicaid average for *Getting Care Quickly*.

For the Children with Chronic Conditions population, the FAMIS program scored 70.3 percent for *Rating of Specialist Seen Most Often*, which exceeded the national Medicaid average. The FAMIS program scored 5 or more percentage points below the national Medicaid average for *Rating of Health Plan* and *Customer Service*. For the FAMIS program, HSAG recommends that DMAS focus on

quality improvement (QI) initiatives related to *Getting Care Quickly*, *Customer Service*, and *Rating of Health Plan*.

DMAS also contracted with HSAG to report on the results of the CAHPS surveys (Adult and Child) administered by each MCO for the Medallion 3.0 population. For the Adult survey, the aggregate MCO scores were higher than the national Medicaid average for all eight measures that could be compared to the national average. The MCOs varied in their performance, ranging from Anthem scoring above the national average on all eight measures to INTotal scoring above the national average on four measures. Relative to health plan operations, Anthem, Optima, and VA Premier scored above the national average on *Rating of Health Plan;* and all MCOs except INTotal scored above the national average for *Customer Service*. Relative to health care, all MCOs scored above the national average for *Rating of Personal Doctor* and *Getting Needed Care*.

For the Child survey, the aggregate program scored above the national average for seven of the eight measures, with *Customer Service* ratings scoring below the national average. The MCOs varied in performance, ranging from Optima, with six ratings above the national average, to INTotal, with two ratings above the national average. For the Medallion 3.0 MCOs, HSAG recommends that MCOs focus on individual measures with scores below the national Medicaid average. For the Medallion 3.0 population, HSAG recommends that the MCOs focus quality initiatives on plan-specific measures with scores below the national average.

The MCOs who are contracted with DMAS for delivering care to eligible Medicaid managed care members are the same MCOs who deliver care to FAMIS eligible members. While the FAMIS CAHPS survey administered by HSAG also includes fee-for-service, the MCO quality collaborative is encouraged to compare the statewide FAMIS program's general child CAHPS survey results to the child Medicaid CAHPS results of the Medallion 3.0 MCOs in aggregate. Of the seven measures for which comparisons were performed, the FAMIS program scored higher than the Medallion 3.0 child population on one measure, *Rating of All Health Care*. For the remaining six comparable measures, the Medallion 3.0 child population scored higher than the FAMIS program; however, there was only one measure, *Getting Care Quickly*, where the FAMIS program scored more than 5 percentage points lower than Medallion 3.0 child population.

2. Commonwealth of Virginia Medicaid Managed Care Overview

Overview

DMAS administers the Medicaid managed care program in the Commonwealth of Virginia, known as Medallion 3.0, in accordance with Title XIX of the SSA. In addition, DMAS administers the Virginia Children's Health Insurance Program (CHIP), known as FAMIS [Family Access to Medical Insurance Security].

Virginia first implemented Medallion, a Medicaid primary care case management (PCCM) program in four pilot cities in 1993. The program was expanded statewide in 1995 and covered low-income adults and children, and aged, blind, or disabled individuals. Virginia also offered the Options program, which provided for voluntary managed care enrollment for beneficiaries in certain regions. In 1996, Virginia implemented Medallion II, a comprehensive managed care program in which enrollment was mandatory for most children, low-income adults, and non-dual-eligible aged and disabled individuals. Subsequently, the PCCM program was eliminated and the MCO managed care program was expanded statewide. In July 2014, Medallion 3.0 was implemented, which incorporated new partnership initiatives, quality incentives, foster care, and an expedited enrollment process to facilitate access to services.

In March 2014, DMAS, in partnership with CMS, implemented a Financial Alignment Demonstration program, Commonwealth Coordinated Care (CCC), which integrates Medicaid and Medicare benefits for select dual-eligible enrollees. The CCC program seeks to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports (LTSS) to improve health outcomes for enrollees who often have very complex needs. A separate EQR technical report has been developed for the CCC program, covering the report period of January 1 through December 31, 2015.

Managed Care Organization Profiles

During 2015, DMAS contracted with six qualified MCOs to provide services to managed care members. Following is a brief description of each MCO.

- Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. (Anthem) is a Virginia Health Maintenance Organization (HMO) affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate health care company, headquartered in Indianapolis, Indiana.
- CoventryCares of Virginia (Coventry) is the name of the Medicaid/FAMIS Plus program offered by Coventry Health Care of Virginia. Coventry Health Care, Inc., was acquired by Aetna in 2013, a multistate health care benefits company, headquartered in Hartford, Connecticut.
- INTotal Health (INTotal), headquartered in Falls Church, Virginia, manages Medicaid health insurance programs in Virginia and is part of Inova, a not-for-profit health care system based in northern Virginia serving the greater Washington D.C. area.

- Kaiser Permanente is a partnership of the non-for-profit Kaiser Foundation Health Plan and its regional operating subsidiaries, Kaiser Foundation Hospitals, and the Permanente Medical Groups. The company was founded in 1945 and is based in Oakland, California.
- Optima Family Care (Optima) is the name of the Medicaid managed care product offered by Optima Health. A service of Sentara, Optima is a not-for-profit health care organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia.
- Virginia Premier Health Plan, Inc. (VA Premier) is a local, not-for-profit managed care organization owned by the Virginia Commonwealth University Medical Center, headquartered in Richmond, Virginia. The company began operations as a managed care Medicaid health plan in 1996.

Refer to Table 2-1 below for MCO profiles as of December 2015.

Table 2-1—MCO Profiles as of December 2015

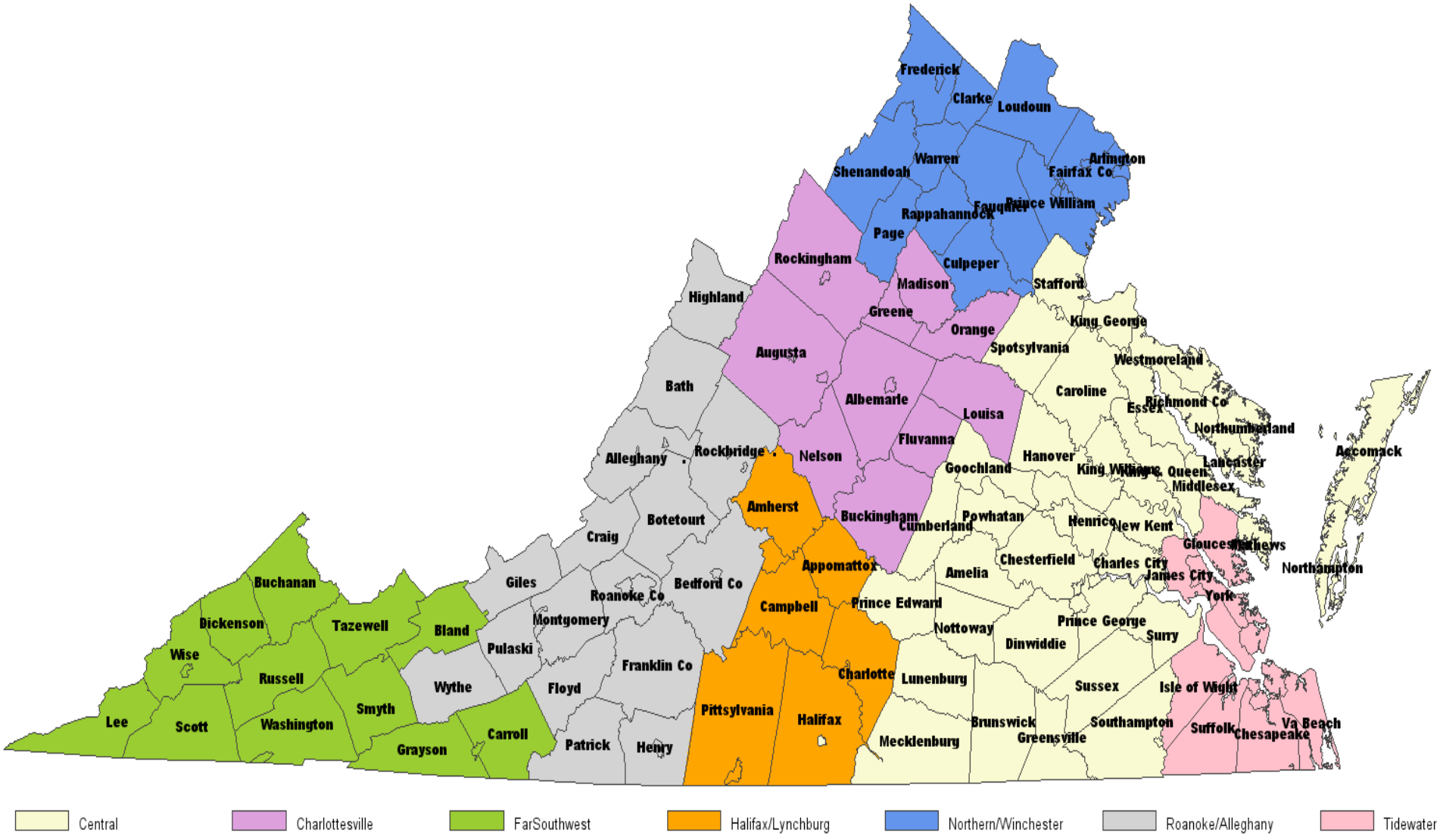
MCO	Year Operations as MCO in Virginia Began	Product Lines in Virginia
Anthem	1996	Medicaid, Medicare, Commonwealth Coordinated Care, Commercial
Coventry	1996	Medicaid, Commercial
INTotal	2013	Medicaid
Kaiser Permanente	2014	Medicaid, Medicare, Commercial
Optima	1995	Medicaid, Medicare, Commercial
VA Premier	1995	Medicaid, Medicare, Commonwealth Coordinated Care, Commercial

As of December 2015, the six MCOs served over 749,000 individuals in a Medicaid and FAMIS managed care program. Table 2-2 below shows the enrollment by population for each MCO and Figure 2-1 displays a map of the managed care regions for the population.

Table 2-2—Virginia Medicaid Managed Care Enrollment by MCO and Population as of December 2015

MCO	Medallion 3.0	FAMIS	Total
Anthem	256,267	24,620	280,887
Coventry	38,503	2,166	40,669
INTotal	52,357	5,797	58,154
Kaiser Permanente	7,676	1,090	8,766
Optima	163,037	10,472	173,509
VA Premier	175,873	11,154	187,027
Grand Total	**693,713**	**55,299**	**749,012**

Figure 2-1—Virginia Managed Care Regions



Quality Strategy

42 CFR §438.202(a) requires states with Medicaid managed care to have a written quality strategy. DMAS published its first quality strategy in June 2005. The strategy was updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued an addendum to the 2011–2015 managed care quality strategy as a companion to the previously published second edition. This addendum was the result of the May 2015 release of the Proposed Rule to modernize and update the federal Medicaid managed care regulations. The addendum addresses the progression of and impending changes to managed care quality in Virginia.

The Virginia quality strategy was designed to serve as a blueprint for continuous quality improvement of health care services provided by the Medicaid and CHIP managed care delivery system. Through contractual requirements, DMAS holds the MCOs accountable for quality-related activities, review, and results that meet (and in certain areas exceed) federal managed care requirements as set forth in 42 CFR Subparts D and E.

DMAS contracted with HSAG during the 2015 review period to conduct two of the three federally mandated EQR activities, including annual validation of performance measures (refer to Section V) and annual validation of PIPs (refer to Section VI). The third mandated activity, comprehensive review of MCO compliance with standards, was last conducted in 2014 and is to be conducted every three years (refer to Section IV).

In addition to compliance with federal standards, Virginia was one of the first states to require all contracted MCOs to achieve and maintain NCQA accreditation. As of 2015, all six MCOs held accredited or commendable NCQA accreditation status.

DMAS also contracted with HSAG to conduct three focused quality studies, Improving Birth Outcomes through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Health and Acute Care Program (refer to Section VII); required the MCOs to conduct and report results of CAHPS surveys for the Medallion 3.0 and FAMIS populations (refer to Section IX); initiated a program for encounter data validation (refer to Section VIII); and provided technical assistance on the development of a Consumer Decision Support Tool.

Through its quality strategy, DMAS had a systematic approach in place to monitor, and to identify and act on opportunities for improvement in, the quality of care and services delivered to MCO members.

Quality Initiatives

Managed Care Quality Collaborative

The Medicaid Managed Care Quality collaborative has been active for more than a decade and is facilitated by DMAS QI staff, meeting four times per year in Richmond. The MCOs, the EQRO, and DMAS have used the collaborative to develop innovative programs and potential solutions to target the needs of Medicaid members.

DMAS hosted quarterly quality collaborative meetings with all contracted MCOs in 2015. The purpose of the collaborative meetings was to facilitate the sharing of information between DMAS and the MCOs, with the goal of improving the quality of care and services provided to Medicaid members. Some of the topics presented and/or discussed in these meetings are described below.

Foster Care Children in Managed Care

As of January 2015, a total of 4,617 foster care children were enrolled in managed care, representing 85 percent of all foster care children receiving Medicaid services in Virginia. Among foster care youth continuously enrolled for a year or longer with the same MCO, 95 percent were seen by a primary care physician (PCP) within the first year of enrollment, compared to 91 percent for foster care children in fee-for-service (FFS). The MCOs reached out to those members who had not been seen by a PCP to encourage a visit.

DMAS Medicaid data showed that the most common behavioral health diagnoses for foster care children ages 0–5 were related to developmental delays. Of foster care children ages 0–3 who received Early Intervention (EI) screenings and assessments in 2014, 94.5 percent were screened and assessed for EI service access. For the remaining 5.5 percent, DMAS followed up with the appropriate Department of Social Services (DSS) agency to schedule a screening or assessment.

Of 387 foster care children who were placed in a residential treatment center (RTC) in 2014, 75 percent were enrolled in an MCO prior to placement. DMAS is developing a discharge plan to notify MCOs when a child is admitted to and discharged from an RTC to facilitate continuity of care.

Assessing Children with Special Healthcare Needs

Common MCO barriers and challenges to assessing members with special healthcare needs were identified, including inaccurate contact information, lack of member engagement, missing elements in the assessment tool, and using the incorrect methodology for identifying eligible members.

Approaches to improve processes were discussed, including:

- Reviewing the assessment tool to ensure all contractually required elements are captured.
- Sending the assessment form to the member prior to telephonic communication.
- Reconciling the MCO/DMAS data files for a list of members requiring an assessment.

- Establishing an internal evaluation team with key leaders to meet regularly to assess progress.
- Streamlining the assessment collection process and forms.
- Using correct methodology consistent with the Managed Care Technical Manual specifications.
- Creating a separate assessment tool for children and adults.
- Outreach staff attempting home visits when mail and phone contact attempts are unsuccessful.

Virginia Immunization Information System (VIIS)

The Virginia Department of Health (VDH) presented information on the Virginia Immunization Information System (VIIS). The impact of vaccinations on cases of specific diseases was discussed, along with the estimated vaccination coverage for children 19 to 35 months of age.

The VIIS is a secure web-based database that tracks immunization information for individual patients, designed to provide clinicians with a current comprehensive patient immunization history. Providers and health plans submit immunization data to VIIS electronically. VIIS currently includes over seven million clients and 55 million immunizations.

The VIIS is used to provide immunization history to providers, to forecast vaccine recommendations for individual patients, and to identify patients due for vaccines. MCOs can use the VIIS to facilitate accurate reporting of vaccine administration and to assist in outreach to members needing vaccines.

Performance Improvement Project (PIP) Topics and Training

In addition to providing information on the MCO PIP validation process for 2015, the planned transition to a rapid-cycle improvement model was discussed. The new model is more proactive and outcome-oriented, placing greater emphasis on improving outcomes using rapid-cycle methods to pilot small changes.

In October 2015, DMAS received approval from CMS to transition from the traditional PIP validation model to the rapid-cycle improvement model, and to complete and validate the first few modules of the new PIP model by the end of 2016. Between January and June 2016, retraining and start-up of the rapid-cycle PIP are scheduled to take place. From July to December 2016, MCOs will implement the new PIP process and HSAG will validate the PIPs to the point of progression.

Performance Incentive Awards Program

Description of Program

In alignment with goals and objectives of managed care quality improvement in Virginia, the Performance Incentive Award (PIA) program was created to improve health outcomes for members in FAMIS and Medallion 3.0 populations, and promote and incentivize MCOs' high performance on six measures representing two measurement domains. For the first domain, administrative measures, DMAS selected the following measures:

- *Assessments of Foster Care Population*
- *MCO Claims Processing*
- *Monthly Reporting Timeliness and Accuracy*

Within the second domain, HEDIS measures, DMAS selected the following measures:

- *Child Immunization Status—Combination 3*
- *Controlling High Blood Pressure*
- *Timeliness of Prenatal Care*

As part of this pay-for-performance incentive program, DMAS elected to pilot this program in 2015 so that no actual penalties or awards were implemented. MCOs' administrative and HEDIS measure rates were collected and scored based on a comparison of MCOs' measure rates to predetermined thresholds. The administrative measures were compared to standards created by DMAS, and MCOs' HEDIS measure rates were compared to national benchmarks for Medicaid managed care as they were reported in Quality Compass. MCOs' HEDIS measure rates were scored using the following methodology:

- Three points (highest performance) were awarded if the MCO's measure rate was equal to or above the Quality Compass 90th percentile.
- Two points (high performance) were awarded if the MCO's measure rate was equal to or above the Quality Compass 75th percentile and below the 90th Quality Compass percentile.
- One point (average performance) was awarded if the MCO's measure rate was equal to or above the Quality Compass 50th percentile and below the 75th Quality Compass percentile.
- Zero points (low performance) were awarded if the MCO's measure rate was below the 50th Quality Compass percentile.

Once the measures were scored and weighted appropriately, total capitation payment amounts were used to calculate theoretical awards and penalties, which was a maximum of 0.15 percent of each MCO's total capitation payment. Since this was a pilot year, no actual awards or penalties were made based on the calculations.

Objectives

This initiative was created to provide financial incentive to Medicaid MCOs to improve the quality, efficiency, and overall value of health care in Virginia. As evidenced by the six measures selected by DMAS for inclusion in the PIA calculation, the program aims to assess MCOs' performance of activities that have been demonstrated to contribute to positive health outcomes for members. The PIA program rewards higher-scoring MCOs to support sustained high performance, and imposes financial penalties on lower-scoring MCOs to promote improved performance in the future.

Status of 2015 Activity

The 2015 activity served as the pilot year to allow DMAS to gain feedback from the MCOs and stakeholders in order to evaluate the program design and methodology, and determine any changes that would be implemented for future years. Therefore, MCOs were not subject to quality awards or penalties, and results were for informational purposes only. HSAG calculated and finalized PIA results for five of the six MCOs in Virginia. Kaiser Permanente was excluded from the analysis since it was not a contracted MCO until 2013.

Upon review of the MCOs' pilot year results, DMAS elected to adopt the same administrative measure scoring methodology in 2016 that was used for the pilot year, but modify the HEDIS measure scoring methodology to take into consideration MCOs' upper and lower confidence intervals compared to Quality Compass percentile values. Therefore, for the 2016 PIA score calculation, MCOs' HEDIS measure rates will be compared to national benchmarks for Medicaid managed care as they were reported in Quality Compass. MCOs' HEDIS measure rates will be scored using the following methodology:

- Two points (high performance) will be awarded if the 95 percent confidence interval for an MCO's measure rate is entirely above the Quality Compass 50th percentile.
- One point (average performance) will be awarded if the 95 percent confidence interval for an MCO's measure rate encompasses the Quality Compass 50th percentile.
- Zero points (low performance) will be awarded if the 95 percent confidence interval for an MCO's measure rate is entirely below the Quality Compass 50th percentile.

Additionally, MCOs will be eligible to receive additional points for either improving HEDIS measure rates from the prior year using a *t* test or consistently performing above the national Medicaid 90th percentiles in the prior and current years. With the use of confidence intervals, this updated scoring methodology will help to limit or eliminate instances when MCOs with similar rates receive different scores. The modified methodology also rewards MCOs that show a statistically significant improvement, regardless of whether the MCO met the benchmark. It also rewards plans that are consistently high performers. Further, with HEDIS measures, statistical significance is sometimes a product of large denominators, so small changes in rates can be considered statistically significant due to a large eligible population size, but the recipients might not experience a significant change in plan performance. However, statistically significant changes will likely be indicative of real change in recipient experience since all three HEDIS measures use the hybrid methodology.

Consumer Decision Support Tool

Description of Tool

DMAS contracted with HSAG in 2015 to produce a prototype for a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data. Specifically, HEDIS 2015 performance measure results and 2015 CAHPS data were combined and analyzed to assess MCOs' performance as related to certain areas of interest to consumers.

To derive the results that were included within the tool, HSAG scored each MCO's quality of care provided in the following reporting categories: Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women. For each reporting category, a summary score for each MCO was calculated in order to determine MCO performance. The summary score for each MCO was then compared to the Medicaid MCO Virginia average to determine differences in MCO performance. Each MCO's performance was categorized into one of three performance categories based on the standardized summary scores and the respective confidence intervals (i.e., below average, average, or above average when compared to the average performance across MCOs). HSAG then used a three-level rating scale to report the category rankings (e.g., a standard scale of one star to three stars). The finalized tool included an overview of the tool, description of the reporting categories, and MCO-specific results as well as background information for consumers choosing a Medicaid MCO, including MCO region assignments and contact details.

Objectives

The tool was developed to help support DMAS' public reporting of MCO performance information to be used by consumers to make informed decisions about their health care. Since the tool evaluated individual MCO performance (e.g., on how well doctors involved members in decisions about their care, and if children regularly received checkups and important shots that helped protect them against serious illness), consumers had the opportunity to be better informed in certain areas of interest. Additionally, the tool provided a three-level rating scale with an easy-to-read "picture" of quality performance across MCOs, and presented data in a manner that clearly emphasized meaningful differences between MCOs (i.e., one-to-three star rating) to assist consumers when selecting a health plan.

Status of 2015 Activity

In 2015, HSAG calculated and finalized results for five of the six MCOs in Virginia. Kaiser Permanente was excluded from the analysis since it was not contracted as an MCO until 2013. Since the Consumer Decision Support Tool included only five of the six Medicaid MCOs operating in Virginia, the results were not made publicly available, and 2015 served as the pilot year to allow DMAS to gain feedback from the MCOs and stakeholders in order to determine the most appropriate means for supporting DMAS' public reporting of MCO performance information for future years.

Maternal and Infant Improvement Project

The Maternal and Infant Improvement Project (MIIP) was created by DMAS to improve maternity care for Medicaid and FAMIS beneficiaries. A multidisciplinary team at DMAS was tasked with the goal of developing and implementing rapid-cycle strategies to increase enrollment of pregnant women and maximize access to maternity care for Medicaid and FAMIS MOMS members.

As a result of comprehensive data analysis which identified priority areas of focus, the following initiatives were implemented in 2015.

Birth Outcomes Focused Study

DMAS contracted with HSAG to conduct a focused study, Improving Birth Outcomes through Adequate Prenatal Care. This annual study addresses the following questions:

- To what extent do women with births paid by FFS and managed care Medicaid receive early and adequate prenatal care?
- What clinical outcomes are associated with FFS and managed care Medicaid-paid births?

Activity in 2015 on this study is described in Section VII of this report.

Eligibility Policies and Regulation Review

Eligibility policies and regulations were reviewed through site visits to select providers and stakeholders to gain an understanding of how these are interpreted and implemented at the local level. System modifications were made based on input and included a pilot program to focus on process improvement for member choice in MCO enrollment.

In addition, the MIIP team identified that a modification in eligibility policies in 2012 allowed for full Medicaid eligibility for certain noncitizen, pregnant women and children under 18 years of age without time limits. To ensure that this new policy was implemented at the local level, the MIIP team developed a DMAS Broadcast to all local DSS workers to remind them of this change in policy.

Communication with Providers and Members

The MIIP team worked collaboratively with VDH, the Virginia Hospital and Healthcare Association (VHHA), and the American Congress of Obstetricians and Gynecologists (ACOG) to develop a formal document with nationally recognized standards for prenatal, obstetrical, and postpartum care. The document was endorsed by both the DMAS agency director and the -Commissioner of -Health and was distributed to the provider community.

A flyer promoting Special Supplemental Nutrition Program for *Women, Infants, and Children (WIC)* services for free food and education for pregnant women and their children was also developed and widely distributed to Medicaid and FAMIS enrolled members.

Collaborative Activities

MIIP team members worked collaboratively with key stakeholders, including VHHA and ACOG to serve as champions for messaging on the health and wellbeing of pregnant women and infants to their constituents.

The team members also actively participated in several learning collaboratives, both at the federal and state level, to address a number of issues related to pregnant women and infants, including safe sleep, breastfeeding, promotion of long-acting reversible contraceptives, tobacco cessation, reducing low-risk C-sections, and improving postpartum care.

Fee-for-Service and Managed Care

Smiles for Children Dental Services

Effective March 1, 2015, DMAS implemented the *Smiles for Children* program, which expanded dental care for adult pregnant women enrolled in Medicaid and FAMIS MOMS. With the goal of assisting in the delivery of healthy babies, the program provides appropriate dental services for pregnant women to reduce dental emergencies. Approximately 4,821 pregnant women as of December 2015 have been served since the program's inception.[3-1]

Plan First, Expanded Family Planning Services

The MIIP team completed a comprehensive review of the *Plan First* family planning services benefit with the goal of improving access to and the operation of the benefit program. Family planning services help to increase the intendedness of pregnancies and increase the spacing between births to help promote healthier mothers and infants. Preventing unintended pregnancies has significant social and economic advantages, including savings in health care and social support. The team will make recommendations for improving the program for both the member and provider communities, including a new design for the *Plan First* member identification card.

Review and Modification of Medallion 3.0 Contract

An analysis of the Medallion 3.0 contract deliverables related to maternity care was conducted, with the goal of ensuring explicit DMAS expectations and encouraging consistent program implementation among the MCOs. As a result, a "Maternity Care" section of the contract was created to consolidate all maternity-related requirements in one area. Contract language was also strengthened to ensure that DMAS expectations are clearly outlined. Lastly, standardized reporting requirements and templates were developed for consistent submission of MCO information to DMAS.

Contract Compliance Enforcement Action

MCO compliance with contractual requirements contributes to the quality of health care and services delivered. The DMAS Health Care Services (HCS) Compliance Unit implemented a new contract compliance enforcement action (CCEA) process in 2015, with the goal of detecting and responding to issues of MCO noncompliance and, when necessary, remedying contractual violations.

The CCEA process is based on a tiered approach to enforcing contractual noncompliance, including a six-level deficiency classification. Steps in the process are presented below.

- Monitoring
- Discovery
- Review (Business, Compliance, Management)
- Approval/Disapproval
- Enforcement Action
- Assessment
- Follow-up/Corrective Action

[3-1] DentaQuest, Medicaid Dental Carrier for Virginia, utilization reports, accessed by DMAS in February 2016.

Compliance Review

One of the three federally mandated EQR activities is a review of compliance with federal and state operational standards once every three years. The last operational systems review (OSR) was conducted in 2014, reported on in the 2014 EQR Technical Report, and included a review of the following standards for the seven MCOs contracted with DMAS during CY 2014.[4-1]

- Enrollee Rights
- Grievance System
- Quality Assessment and Performance Improvement

As a result of the OSRs, the MCOs were required to develop corrective action plans (CAPs) for deficiencies identified. The MCOs submitted CAPs to DMAS in July and August 2014, which addressed and resolved the following issues:

- Anthem—The FAMIS member handbook was missing the member's right to be free from restraint and seclusion (isolation) used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion. This right was added to the FAMIS member handbook on page 50 in the Member Rights and Responsibilities section.
- Coventry—The Utilization Management Decision-Making policy did not include the requirement that the MCO must give written notice of the reason for the extension of standard authorization decisions to the member. Coventry amended the policy to state that "The MCO will give written notice of the reason for extensions to members." In addition, Coventry created a Member Extension Letter template and trained Health Services staff on the revised notification process.
- INTotal—The assessment of network adequacy included distance traveled by members to see providers, but it did not provide evidence of analysis against DMAS standards for time traveled by members to see providers. INTotal noted that the largest portion of their membership is located in northern Virginia, which is ranked highest in traffic congestion and travel time in the United States. The Travel Time Index for the area demonstrates wide variations in trip times and prevents a consistent and reliable analysis of time traveled by members to see providers. INTotal noted that it would continue to analyze network adequacy and monitor member feedback to ensure standards and member needs are met. In addition, INTotal was monitoring authorization timelines in terms of days versus hours and did not differentiate between urgent and nonurgent requests for authorization. INTotal implemented a manual process to monitor timelines through periodic auditing, worked with the system vendor to include date flags and separate cues for urgent requests to ensure timeliness of expedited authorization decisions, and educated providers on appropriate requests for urgent reviews.
- Kaiser Permanente—The appeals policy did not indicate that oral inquiries seeking to appeal an action are treated as appeals to establish the earliest possible filing date for the appeal. Kaiser

[4-1] MajestaCare was a contracted MCO effective until December 1, 2014.

Permanente updated its appeals policy to indicate that oral inquiries seeking to appeal an action are treated as appeals.

- Optima—The Services Requiring Authorization and Timeframes for Decisions policy did not include language that the MCO must mail a notice to the member at least 10 days before the date of action for a termination, suspension, or reduction of a previously authorized service. In addition, the policy did not include the provisions that, for service authorization decisions not reached within the periods specified in 42 CFR §438.210.d, a decision must be made on the date on which the extended period expires. Optima updated the policy to include the required language and conducted a 100 percent review of all denial letters, in addition to random monthly audits for compliance.
- VA Premier—The VPHP UTM-008 policy did not include language that the MCO must mail a notice to the member at least 10 days before the date of action for a termination, suspension, or reduction of a previously authorized service. VA Premier updated the policy to include the required language. In addition, during appeal case file review, information regarding potential member liability for the cost of benefits during an appeal process was not included in the Notice of Action (NOA) or stated in the MCO's Instructions for Members Initiating a Medicaid Appeal. VA Premier updated its NOA and appeals instructions to include the required verbiage. Lastly, the VPHP Medicaid Appeals Process policy did not specifically state that the MCO or State must pay for services if the MCO or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending. The VHP PI-2002 policy was updated to include the required language.

Accreditation

In addition to compliance reviews, Virginia was among the first states to require that contracted MCOs achieve and maintain health plan accreditation by NCQA. Health plan accreditation involves a rigorous evaluation of the quality of health care and services provided, along with an assessment of clinical and member satisfaction performance measures (HEDIS and CAHPS).

NCQA accreditation levels include Excellent, Commendable, Accredited, Provisional, and Interim. Refer to Table 4-1 below for the accreditation levels of the contracted MCOs in 2015.

Table 4-1—MCO NCQA Accreditation Levels

MCO	Accreditation Level
Anthem	Commendable
Coventry	Accredited
INTotal	Accredited
Kaiser Permanente	Commendable*
Optima	Accredited
VA Premier	Commendable

* Kaiser Permanente was rated "Commendable" based on standards only (no HEDIS or CAHPS submissions).

Five of the six contracted MCOs were ranked in the top 100 Medicaid health plans in 2014–2015 by NCQA for consumer satisfaction, prevention, and treatment. Kaiser Permanente was not eligible to be ranked since it was not contracted as a Medicaid MCO in Virginia until 2013 and as a new MCO did not have sufficient data for ranking.

5. Performance Measures

Introduction

One of the mandatory EQR activities set forth in 42 CFR §438.358 involves validation of MCOs' performance measure rates reported to the State during the preceding 12 months. Further, the MCO must measure and report to the State its performance, using standard measures required by the State, or submit to the State data that are specified to enable the State to measure MCO performance. Monitoring of performance measures allows for the assessment of quality of, access to, and timeliness of the care and services provided to Medicaid members.

As part of performance measurement, the Virginia MCOs were required to submit HEDIS data to NCQA. To ensure HEDIS rates are accurate and reliable, NCQA required each MCO to undergo an NCQA HEDIS Compliance Audit by a certified independent auditor. Results of these audits are presented below along with MCO-specific rates for DMAS-defined priority HEDIS measures.

In addition, DMAS contracted with HSAG to conduct PMV on three separate HEDIS measures, *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up*, to evaluate further the accuracy of reported performance measure rates. Lastly, DMAS also contracted with HSAG to calculate the PQI #3: Diabetes Long-Term Complications Admission Rate for the MCOs in aggregate for calendar year (CY) 2014.

NCQA HEDIS Compliance Audit Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess an MCO's ability to report HEDIS data accurately and reliably. Compliance with the guidelines also helps an auditor to understand an MCO's HEDIS reporting capabilities. For HEDIS 2015, MCOs were assessed on seven IS standards. To assess the MCOs' adherence to the IS standards, HSAG reviewed several documents for the Virginia MCOs. These included the MCOs' FARs, IS compliance tools, and the IDSS files approved by an NCQA-licensed audit organization (LO).

Each of the Virginia MCOs contracted with an LO to conduct the NCQA HEDIS Compliance Audit. The MCOs were able to select the LO of their choice. Overall, the Virginia MCOs consistently maintained the same LOs across reporting years.

As in the prior year, all MCOs contracted with an external software vendor for HEDIS measures production and rate calculation. HSAG reviewed the MCOs' FARs and ensured that these software vendors participated in and passed NCQA's Measure Certification process. MCOs could purchase the software with certified measures and generate HEDIS measure results internally or provide all data to the software vendor to generate HEDIS measures for them. Either way, using NCQA-certified measure software may reduce the MCO's burden for reporting and helps to ensure rate validity.

HSAG found that, in general, the MCOs' information systems and processes were compliant with the applicable IS standards and the HEDIS reporting requirements related to the key Virginia Medicaid measures for HEDIS 2015.

Key Information Systems Findings—Summary of MCO Final Audit Reports

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

- Industry standard codes are used and all characters are captured.
- Principal codes are identified and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields relevant to measure reporting, all proprietary forms capture equivalent data, and electronic transmission procedures conform to industry standards.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure the accurate entry of submitted data in transaction files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 1.0, Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry*. All required data elements were captured at a sufficient level of specificity for HEDIS reporting. Only industry standard codes and industry standard forms were accepted. Nonstandard codes, if any, were mapped to industry standard codes appropriately. Adequate validation processes such as built-in edit checks, data monitoring, and quality control audits were in place to ensure that only complete and accurate claims and encounter data were used for HEDIS reporting.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- The organization has procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 2.0, Enrollment Data—Data Capture, Transfer, and Entry*. Enrollment data were received from the State. All fields required for HEDIS reporting were captured. The MCOs were able to process eligibility files in a timely manner. Enrollment information housed in the MCOs' systems was reconciled against the enrollment files provided by the State. Adequate checks and balances were in place to ensure data completeness and data accuracy.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to HEDIS provider specialties necessary for measure reporting.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of practitioner data are checked to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 3.0, Practitioner Data—Data Capture, Transfer, and Entry*. In general all of the MCOs captured provider data accurately and were able to identify rendering provider type for those measures for which this was required. Provider specialties were fully mapped to HEDIS specified provider types. Adequate controls and edit checks were in place for data entered into the credentialing modules to ensure that only accurate data were used for HEDIS reporting. It was identified that INTotal health would need to validate and correct its provider certification data in order to be able to report the board certification measure.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms capture all fields relevant to measure reporting, and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).
- Retrieval and abstraction of data from medical records are reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 4.0, Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight*. Medical record data were used by all MCOs to report HEDIS hybrid

measures. Medical record abstraction tools were reviewed and approved by the MCOs' auditors for HEDIS reporting. Whether through a vendor or by internal staff, all medical record data collection and review were conducted by qualified and experienced professionals. Sufficient validation processes and edit checks were in place to ensure data completeness and data accuracy.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of data have checking procedures to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 5.0, Supplemental Data—Capture, Transfer, and Entry*. Supplemental data sources used by the MCOs were verified and approved by the auditors. Proof of service validation was performed on all nonstandard data sources. Validation processes such as reconciliation between original data source and MCO-specific data systems, edit checks, and system validations ensured data completeness and data accuracy. There were no issues noted with the use of these data; however, the auditors suggested that the MCOs continue to conduct close oversight of their supplemental data systems and processes.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

This standard assesses whether:

- Member call center data are reliably and accurately captured.

IS 6.0 was not applicable to the measures required to be reported by the MCOs.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- Data transfers to the HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting are suitable for measures and enable required programming efforts.

- Report production is managed effectively and operators perform appropriately.
- Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.
- Physical control procedures ensure measure data integrity such as physical security, data access authorization, disaster recovery facilities, and fire protection.

The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 7.0, Data Integration—Accurate HEDIS Reporting Control Procedures That Support HEDIS Reporting Integrity*. As in the prior year, all MCOs contracted a software vendor producing NCQA-certified measures to calculate HEDIS rates. For all MCOs, adequate monitoring processes were in place to ensure that no data were lost during data transfer to HEDIS repositories. Sufficient vendor oversight was in place for MCOs using software vendors.

MCO-Specific HEDIS Measure Results

The following tables present each MCO's HEDIS 2013, 2014, and 2015 performance measure results and the current performance level relative to the NCQA Quality Compass 50th percentile. Select measures and associated measure indicators were eligible for rotation in 2014 (i.e., *Controlling High Blood Pressure* and *Prenatal and Postpartum Care)* and in 2015 (i.e., *Adolescent Well-Care Visits; Childhood Immunization Status; Lead Screening in Children; Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Comprehensive Diabetes Care*). Rotating a measure allows a plan to use the audited and reportable hybrid rate from the prior year rather than collecting the measure for the measurement year. Therefore, MCOs' measure rates may be the same for these measures across two years.

In the tables below, yellow-shaded boxes indicate MCO rates that were at or above the 50th percentile. HEDIS 2015 rates were compared to the 2014 NCQA Quality Compass 50th percentile values shown in the tables below; however, previous years' rates were compared to corresponding years' Quality Compass data (e.g., HEDIS 2014 was compared to the 2013 NCQA Quality Compass 50th percentiles). Certain measures are not appropriate for comparisons to benchmarks (i.e., *Well-Child Visits in the First 15 Months of Life—One, Two, Three, Four, and Five Well-Child Visits* indicators); therefore, 50th percentile values were excluded from the tables and are denoted with gray shading. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.

Anthem

Anthem's HEDIS measure results are shown in Table 5-1.

Table 5-1—Anthem's HEDIS Measure Results

	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.21	45.12	53.24	**48.51**

Table 5-1—Anthem's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Childhood Immunization Status				
Combination 2	72.26	63.57	76.85	**75.18**
Combination 3	67.64	58.70	72.45	**72.33**
Lead Screening in Children				
Lead Screening in Children	66.42	61.72	58.80	**70.86**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	0.49	0.47	2.13	**1.46**
One Well-Child Visit	1.47	0.70	0.80	
Two Well-Child Visits	1.23	0.70	0.80	
Three Well-Child Visits	4.66	3.04	3.46	
Four Well-Child Visits	7.35	8.88	9.31	
Five Well-Child Visits	18.63	17.76	18.88	
Six or More Well-Child Visits	66.18	68.46	64.63	**62.86**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.91	77.26	77.08	**71.76**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	49.46	54.13^	53.71	**57.37**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	88.98	88.98	86.18	**84.30**
Postpartum Care	63.84	63.84	63.47	**62.84**
Care for Chronic Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions				
LDL-C Control (<100 mg/dL)	49.77	40.52	—	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.04	82.51	83.95	**83.88**
HbA1c Control (<8.0%)	55.77	45.07	50.93	**46.43**
Eye Exam (Retinal) Performed	52.56	45.74	46.51	**54.14**
LDL-C Screening	76.28	74.66	—	—
LDL-C Control (<100 mg/dL)	39.10	33.18	—	—
Blood Pressure Control (<140/90 mm Hg)	62.04	54.93	61.63	**61.31**
Controlling High Blood Pressure				
Controlling High Blood Pressure	55.73	55.73	58.24	**56.46**
Use of Appropriate Medications for People with Asthma				
5–11 Years	89.53	90.83	90.30	**91.11**
12–18 Years	85.28	87.33	84.57	**87.31**
19–50 Years	65.01	68.84	63.60	**75.83**

Table 5-1—Anthem's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
51–64 Years	65.33	58.28	64.32	**71.63**
Total	84.82	85.38	83.64	**84.96**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	54.55	48.11	50.03	**49.66**
Effective Continuation Phase Treatment	39.74	33.01	36.81	**33.93**
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	53.72	33.87	31.42	**42.30**
30-Day Follow-Up	75.57	61.42	60.09	**64.63**

[1] 2014 NCQA Quality Compass 50th percentile values are provided for informational purposes. Gray-shaded boxes are displayed for measures where comparisons to the benchmark were not appropriate. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.

[2] A lower rate indicates better performance for this measure.

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the 2013 NCQA Quality Compass 50th percentile. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

— Indicates the measure was retired and was not included in HEDIS 2015 reporting; therefore, the HEDIS 2015 rate and corresponding NCQA Quality Compass 50th percentile value are not presented.

Indicates the rate was at or above the corresponding Quality Compass 50th percentile (e.g., HEDIS 2015 Rate [CY2014] was at or above the 2014 NCQA Quality Compass 50th percentile).

Anthem's Children's Preventive Care measure rates met or exceeded the Quality Compass 50th percentiles for five of the seven measure indicators with benchmarks in 2015: *Adolescent Well-Care Visits*, *Childhood Immunization Status—Combination 2*, *Childhood Immunization Status—Combination 3*, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Anthem also consistently met or exceeded the Quality Compass 50th percentiles for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* from 2013 to 2015. Performance remained unchanged for *Adolescent Well-Care Visits* from 2013 to 2014; however, Anthem's performance improved by more than 9 percentage points from 2013 to 2015. Anthem's rates for the *Childhood Immunization Status—Combination 2* and *Combination 3* measure indicators both decreased from 2013 to 2014, but performance improved in 2015 to a rate above the original performance level reported in 2013.

Anthem's performance consistently declined each year for the *Lead Screening in Children* measure rate, with a decrease of approximately 8 percentage points from 2013 to 2015. In 2015, the *Lead Screening in Children* measure rate was 12 percentage points below the Quality Compass 50th percentile, further demonstrating an opportunity for improvement. Additionally, the rates for *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* indicated similar or better performance than the Quality Compass 50th percentiles and remained stable from 2013 to 2014; however, the 2015 rate increased by more than four times the 2014 rate, indicating performance decline.

Within the Women's Health measure set, rates remained stable for all measure indicators from 2013 to 2015. Notably, Anthem consistently met or exceeded the Quality Compass 50th percentiles for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in 2013, 2014, and 2015, and Anthem's rate for *Prenatal and Postpartum Care—Postpartum Care* was at or above the Quality Compass 50th percentile in 2015.

Anthem's rates met or exceeded the Quality Compass 50th percentiles for four of the 10 Care for Chronic Conditions measure indicators with benchmarks in 2015, including *Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, CDC—HbA1c Control (<8.0%), CDC—Blood Pressure Control (<140/90 mm Hg),* and *Controlling High Blood Pressure.*

Within the area of comprehensive diabetes care, Anthem's rate for *CDC—HbA1c Control (<8.0%)* met or exceeded the Quality Compass 50th percentile in 2013, and subsequently declined in 2014. However, performance improved in 2015, which returned the *CDC—HbA1c Control (<8.0%)* rate closer to Anthem's 2013 performance rate. Similarly, Anthem showed a decline in performance for *CDC—Blood Pressure Control (<140/90 mm Hg),* with a decrease of more than 7 percentage points from 2013 to 2014, but performance improved from 2014 to 2015 with an increase of more than 6 percentage points. Conversely, Anthem's *CDC—Eye Exam (Retinal) Performed* rate declined by approximately 7 percentage points from 2013 to 2014, and performance in this area remained unchanged from 2014 to 2015. Further, the rates for the *Use of Appropriate Medications for People with Asthma—19–50 Years* measure indicator were similar in 2013, 2014, and 2015, but when compared to the Quality Compass 50th percentile, the 2015 rate was more than 12 percentage points below the benchmark, indicating an opportunity for improvement.

For the Behavioral Health measure set, Anthem's rates remained consistent and were at or above the Quality Compass 50th percentiles for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators in 2013 and 2015. Although rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators were at or above the Quality Compass 50th percentiles in 2013, Anthem's performance for these indicators declined in 2014 by approximately 20 and 14 percentage points, respectively. Performance for these measure indicators remained stable from 2014 to 2015, and the 2015 rate for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator was 11 percentage points below the Quality Compass 50th percentile.

Coventry

Coventry's HEDIS measure results are shown in Table 5-2.

Table 5-2—Coventry's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.91	49.77	50.85*	**48.51**
Childhood Immunization Status				
Combination 2	71.05	71.06	65.69	**75.18**
Combination 3	64.96	64.58	60.58	**72.33**
Lead Screening in Children				
Lead Screening in Children	72.75	67.59	71.29	**70.86**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	1.79	1.24	1.02	**1.46**
One Well-Child Visit	1.53	0.74	1.53	
Two Well-Child Visits	4.34	1.49	2.55	
Three Well-Child Visits	5.36	6.44	4.34	
Four Well-Child Visits	8.67	12.62	10.46	
Five Well-Child Visits	15.05	16.09	18.11	
Six or More Well-Child Visits	63.27	61.39	61.99	**62.86**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.77	74.26	68.85	**71.76**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	59.65	60.73^	53.80	**57.37**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	88.80	88.80+	85.64	**84.30**
Postpartum Care	65.03	65.03+	64.89	**62.84**
Care for Chronic Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions				
LDL-C Control (<100 mg/dL)	42.53	39.09	—	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	80.54	82.87	83.21	**83.88**
HbA1c Control (<8.0%)	45.26	47.69	48.42	**46.43**
Eye Exam (Retinal) Performed	58.64	49.54	54.26	**54.14**
LDL-C Screening	70.32	74.31	—	—
LDL-C Control (<100 mg/dL)	33.58	33.10	—	—

Table 5-2—Coventry's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Blood Pressure Control (<140/90 mm Hg)	61.80	59.95	58.15	**61.31**
Controlling High Blood Pressure				
Controlling High Blood Pressure	57.18	57.18+	58.56	**56.46**
Use of Appropriate Medications for People with Asthma				
5–11 Years	93.21	90.58	88.59	**91.11**
12–18 Years	89.80	83.33	85.44	**87.31**
19–50 Years	70.97	66.67	66.37	**75.83**
51–64 Years	NA	NA	51.35	**71.63**
Total	87.90	82.97	82.00	**84.96**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.69	50.12	46.71	**49.66**
Effective Continuation Phase Treatment	36.52	34.87	29.25	**33.93**
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	48.38	42.93	28.95	**42.30**
30-Day Follow-Up	73.38	66.32	54.79	**64.63**

[1] 2014 NCQA Quality Compass 50th percentile values are provided for informational purposes. Gray-shaded boxes are displayed for measures where comparisons to the benchmark were not appropriate. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.

[2] A lower rate indicates better performance for this measure.

** Indicates this measure rate was modified and resubmitted as a result of the performance measure validation activity performed by HSAG. The rate in this table is the original rate included in the auditor-locked IDSS file. The HSAG-validated rate is presented below within the Performance Measure Validation Findings section.*

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the 2013 NCQA Quality Compass 50th percentile. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

+ Indicates the measure rate was reported using the auditor-locked IDSS file; however, this rate was reported differently in the 2014 Annual Technical Report using rates reported directly to DMAS.

— Indicates the measure was retired and was not included in HEDIS 2015 reporting; therefore, the HEDIS 2015 rate and corresponding NCQA Quality Compass 50th percentile value are not presented.

NA indicates that the rate represented a population too small for reporting purposes and was not included in the performance calculations.

Indicates the rate was at or above the corresponding Quality Compass 50th percentile (e.g., HEDIS 2015 Rate [CY2014] was at or above the 2014 NCQA Quality Compass 50th percentile).

Within the Children's Preventive Care measure set, Coventry's rates met or exceeded the Quality Compass 50th percentiles for three of the seven measures with benchmarks in 2015, including *Adolescent Well-Care Visits, Lead Screening in Children,* and *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*. Coventry also performed at or above the Quality Compass 50th percentile for *Adolescent Well-Care Visits* in 2014 and *Lead Screening in Children* in 2013. Further, the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* rate demonstrated

performance improvement each year from 2013 to 2015. Conversely, Coventry's rate of *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* was at or above the Quality Compass 50th percentiles in 2013 and 2014; however, performance declined in 2015, and Coventry did not meet the Quality Compass 50th percentile. Further, the rates for the *Childhood Immunization Status—Combination 2* and *Combination 3* measure indicators were similar in 2013, 2014, and 2015. However, compared to the Quality Compass 50th percentile, the *Childhood Immunization Status—Combination 2* rate was approximately 9 percentage points below and *Childhood Immunization Status—Combination 3* rate was approximately 12 percentage points below the benchmarks in 2015, indicating opportunities for improvement.

For Women's Health, Coventry's rates consistently met or exceeded the Quality Compass 50th percentiles for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators from 2013 to 2015. Conversely, the rate for *Breast Cancer Screening* decreased by approximately 7 percentage points from 2014 to 2015, indicating performance decline.

Coventry's rates met or exceeded the Quality Compass 50th percentiles for three of the 10 Care for Chronic Conditions measure indicators with benchmarks in 2015: *Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%), CDC—Eye Exam (Retinal) Performed,* and *Controlling High Blood Pressure.* For the *CDC—Eye Exam (Retinal) Performed* measure indicator, Coventry's rate was at or above the Quality Compass 50th percentile in 2013, the rate decreased in 2014, and subsequently increased in 2015, which moved the rate closer to Coventry's 2013 performance rate. In contrast, Coventry's *Use of Appropriate Medications for People with Asthma* indicator rates showed opportunities for improvement. Specifically, the rate for the *5–11 Years* measure indicator decreased consistently each year, which resulted in a decrease of approximately 5 percentage points from 2013 to 2015. Also, the 2015 rate for the *51–64 Years* indicator was 20 percentage points below the Quality Compass 50th percentile.

Rates for measures within the Behavioral Health measure set indicate an overall performance decline from 2013 to 2015. For every measure indicator, Coventry's performance decreased each year. Further, the rates for all four measure indicators met or exceeded the Quality Compass 50th percentiles in 2013, and none of the measures achieved the Quality Compass 50th percentiles in 2015. Specifically, the 2015 rate for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator was 13 percentage points below the Quality Compass 50th percentile.

INTotal

INTotal's HEDIS measure results are shown in Table 5-3.

Table 5-3—INTotal's HEDIS Measure Results

	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.44	43.05	42.26*	**48.51**
Childhood Immunization Status				
Combination 2	78.47	75.06	75.43	**75.18**
Combination 3	75.69	69.54	71.78	**72.33**
Lead Screening in Children				
Lead Screening in Children	70.60	66.45	67.40	**70.86**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	1.37	1.99	2.30	**1.46**
One Well-Child Visit	1.64	0.88	0.51	
Two Well-Child Visits	2.73	2.87	2.04	
Three Well-Child Visits	3.01	4.42	3.83	
Four Well-Child Visits	8.20	9.05	11.22	
Five Well-Child Visits	18.31	19.65	18.37	
Six or More Well-Child Visits	64.75	61.15	61.73	**62.86**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.23	76.82	78.69	**71.76**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	48.29	45.37^	45.11	**57.37**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.85	86.85	72.02	**84.30**
Postpartum Care	61.50	61.50	52.55	**62.84**
Care for Chronic Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions				
LDL-C Control (<100 mg/dL)	43.24	34.29	—	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	87.80	85.02	85.89	**83.88**
HbA1c Control (<8.0%)	48.78	36.44	46.96	**46.43**
Eye Exam (Retinal) Performed	53.44	38.46	45.26	**54.14**
LDL-C Screening	80.27	79.15	—	—

Table 5-3—INTotal's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
LDL-C Control (<100 mg/dL)	35.03	25.10	—	—
Blood Pressure Control (<140/90 mm Hg)	58.98	55.87	59.12	**61.31**
Controlling High Blood Pressure				
Controlling High Blood Pressure	54.05	54.05	55.50	**56.46**
Use of Appropriate Medications for People with Asthma				
5–11 Years	87.62	90.07	88.97	**91.11**
12–18 Years	90.68	86.49	82.35	**87.31**
19–50 Years	85.00	76.79	67.06	**75.83**
51–64 Years	NA	NA	71.88	**71.63**
Total	87.94	86.44	82.79	**84.96**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.54	48.96	48.31	**49.66**
Effective Continuation Phase Treatment	34.41	34.03	33.11	**33.93**
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	29.03	24.55	22.78	**42.30**
30-Day Follow-Up	52.07	50.45	48.26	**64.63**

[1] 2014 NCQA Quality Compass 50th percentile values are provided for informational purposes. Gray-shaded boxes are displayed for measures where comparisons to the benchmark were not appropriate. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.

[2] A lower rate indicates better performance for this measure.

** Indicates this measure rate was modified and resubmitted as a result of the performance measure validation activity performed by HSAG. The rate in this table is the original rate included in the auditor-locked IDSS file. The HSAG-validated rate is presented below within the Performance Measure Validation Findings section.*

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the 2013 NCQA Quality Compass 50th percentile. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

— Indicates the measure was retired and was not included in HEDIS 2015 reporting; therefore, the HEDIS 2015 rate and corresponding NCQA Quality Compass 50th percentile value are not presented.

NA indicates that the rate represented a population too small for reporting purposes and was not included in the performance calculations.

Indicates the rate was at or above the corresponding Quality Compass 50th percentile (e.g., HEDIS 2015 Rate [CY2014] was at or above the 2014 NCQA Quality Compass 50th percentile).

Within the Children's Preventive Care measure set, INTotal's measure rates met or exceeded the Quality Compass 50th percentiles for two of the seven measure indicators with benchmarks in 2015, including *Childhood Immunization Status—Combination 2* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. INTotal also met or exceeded the Quality Compass 50th percentile for *Childhood Immunization Status—Combination 2* in 2013, and INTotal consistently met or exceeded the Quality Compass 50th percentiles for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years*

of Life from 2013 to 2015. INTotal's rates remained stable for most of the Children's Preventive Care measure indicators from 2013 to 2015, with the exception of the number of children who had zero *Well-Child Visits in the First 15 Months of Life*—INTotal's performance consistently declined each year, resulting in an overall unfavorable change of almost 70 percent from 2013 to 2015.

None of INTotal's rates in the Women's Health measure set achieved the Quality Compass 50th percentiles in 2015. Although the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rates were consistently at or above the Quality Compass 50th percentiles in 2013 and 2014, INTotal's performance declined in 2015 by approximately 15 percentage points and fell short of the Quality Compass 50th percentile by more than 12 percentage points. INTotal's *Prenatal and Postpartum Care—Postpartum Care* rates were stable from 2013 to 2014, but performance declined by 9 percentage points from 2014 to 2015, and INTotal failed to meet the Quality Compass 50th percentile by 10 percentage points in 2015. Further, the 2015 rate for *Breast Cancer Screening* was 12 percentage points below the Quality Compass 50th percentile.

For the Care for Chronic Conditions measure set, INTotal met or exceeded the Quality Compass 50th percentiles for three of the 10 measure indicators with benchmarks in 2015, including *Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, CDC—HbA1c Control (<8.0%),* and *Use of Appropriate Medications for People with Asthma—51–64 Years.* INTotal also consistently met or exceeded the Quality Compass 50th percentiles for *CDC—HbA1c Testing* from 2013 to 2015. INTotal's rate for *CDC—HbA1c Control (<8.0%)* met or exceeded the Quality Compass 50th percentile in 2013, but subsequently declined and fell short of the Quality Compass 50th percentile in 2014. However, performance improved in 2015, which moved the rate closer to INTotal's 2013 performance rate. Conversely, for the *CDC—Eye Exam (Retinal) Performed* measure indicator, INTotal's rate was at or above the Quality Compass 50th percentile in 2013, and performance decreased by 8 percentage points from 2013 to 2015. Further, INTotal's performance consistently declined each year for the *Use of Appropriate Medications for People with Asthma—12–18 Years* and *19–50 Years* measure indicators, which represents a decrease of 8 and 18 percentage points, respectively, from 2013 to 2015.

Although INTotal previously met or exceeded the Quality Compass 50th percentiles for two measure indicators in the Behavioral Health measure set (i.e., *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment)*, none of INTotal's Behavioral Health measure rates met the Quality Compass 50th percentiles in 2015. Further, INTotal's performance consistently declined each year for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure rates, which were 20 and 16 percentage points below the Quality Compass 50th percentiles in 2015, respectively.

Optima

Optima's HEDIS measure results are shown in Table 5-4.

Table 5-4—Optima's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	47.24	46.53	46.53*	**48.51**
Childhood Immunization Status				
Combination 2	70.58	70.60	70.60	**75.18**
Combination 3	67.04	65.97	65.97	**72.33**
Lead Screening in Children				
Lead Screening in Children	72.21	71.59	71.59	**70.86**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	0.53	0.56	0.56	**1.46**
One Well-Child Visit	1.33	1.39	1.39	
Two Well-Child Visits	1.33	2.22	2.22	
Three Well-Child Visits	3.72	3.33	3.33	
Four Well-Child Visits	7.71	6.94	6.94	
Five Well-Child Visits	13.56	15.00	15.00	
Six or More Well-Child Visits	71.81	70.56	70.56	**62.86**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.75	71.32	71.39	**71.76**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	50.27	57.43^	55.87	**57.37**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.66	83.66	75.29	**84.30**
Postpartum Care	65.34	65.34	58.28	**62.84**
Care for Chronic Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions				
LDL-C Control (<100 mg/dL)	60.00	55.18	—	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.50	84.41	84.95	**83.88**
HbA1c Control (<8.0%)	52.24	50.56	53.70	**46.43**
Eye Exam (Retinal) Performed	48.61	48.55	45.83	**54.14**
LDL-C Screening	75.27	76.39	—	—
LDL-C Control (<100 mg/dL)	55.65	53.01	—	—

Table 5-4—Optima's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Blood Pressure Control (<140/90 mm Hg)	51.81	52.34	56.71	**61.31**
Controlling High Blood Pressure				
Controlling High Blood Pressure	51.18	54.53	48.72	**56.46**
Use of Appropriate Medications for People with Asthma				
5–11 Years	91.54	91.81	91.28	**91.11**
12–18 Years	87.42	88.40	86.89	**87.31**
19–50 Years	74.90	74.00	73.71	**75.83**
51–64 Years	73.94	76.47	75.64	**71.63**
Total	86.91	86.98	86.29	**84.96**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.51	44.85	46.39	**49.66**
Effective Continuation Phase Treatment	36.40	32.05+	33.38	**33.93**
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	60.14	39.73	38.73	**42.30**
30-Day Follow-Up	76.75	62.61	63.66	**64.63**

[1] 2014 NCQA Quality Compass 50th percentile values are provided for informational purposes. Gray-shaded boxes are displayed for measures where comparisons to the benchmark were not appropriate. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.

[2] A lower rate indicates better performance for this measure.

** Indicates this measure rate was modified and resubmitted as a result of the performance measure validation activity performed by HSAG. The rate in this table is the original rate included in the auditor-locked IDSS file. The HSAG-validated rate is presented below within the Performance Measure Validation Findings section.*

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the 2013 NCQA Quality Compass 50th percentile. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

+ Indicates the measure rate was reported using the auditor-locked IDSS file; however, this rate was reported differently in the 2014 Annual Technical Report using rates reported directly to DMAS.

— Indicates the measure was retired and was not included in HEDIS 2015 reporting; therefore, the HEDIS 2015 rate and corresponding NCQA Quality Compass 50th percentile value are not presented.

Indicates the rate was at or above the corresponding Quality Compass 50th percentile (e.g., HEDIS 2015 Rate [CY2014] was at or above the 2014 NCQA Quality Compass 50th percentile).

Regarding Children's Preventive Care, Optima's rates remained stable for all measure indicators within this measure set from 2013 to 2015, and measure rates met or exceeded the Quality Compass 50th percentiles for three of the seven measure indicators with benchmarks in 2015, including *Lead Screening in Children, Well-Child Visits in the First 15 Months of Life—No Well-Child Visits,* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits.* Also, the measure rate for *Lead Screening in Children* was at or above the Quality Compass 50th percentile in 2013, and Optima consistently met or exceeded the Quality Compass 50th percentiles for the *Well-Child*

Visits in the First 15 Months of Life—No Well-Child Visits and *Six or More Well-Child Visits* measure indicators from 2013 to 2015.

For the Women's Health measure set, none of Optima's rates met the Quality Compass 50th percentiles in 2015. Performance in the area of prenatal and postpartum care remained stable, and Optima consistently met or exceeded the Quality Compass 50th percentiles for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator in 2013 and 2014; however, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rate decreased by 8 percentage points and the *Prenatal and Postpartum Care—Postpartum Care* rate decreased by 7 percentage points from 2014 to 2015, indicating a performance decline.

Optima's rates consistently met or exceeded the Quality Compass 50th percentiles from 2013 to 2015 for five of the 10 Care for Chronic Conditions measure indicators with benchmarks: *Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, CDC—HbA1c Control (<8.0%), Use of Appropriate Medications for People with Asthma—51–64 Years,* and *Use of Appropriate Medications for People with Asthma—Total.* Also, rates consistently met or exceeded the Quality Compass 50th percentiles for *Use of Appropriate Medications for People with Asthma—5–11 Years* in 2014 and 2015. Optima's rates were at or above the Quality Compass 50th percentiles for *Use of Appropriate Medications for People with Asthma—12–18 Years* measure indicator in 2013 and 2014; however, the rate decreased in 2015 and did not achieve the Quality Compass 50th percentile.

None of Optima's rates in the Behavioral Health measure set met or exceeded the Quality Compass 50th percentiles in 2015. Although all four rates met or exceeded the Quality Compass 50th percentiles in 2013, Optima's rates declined in 2014 and remained low in 2015. Most notably, the rate for *Antidepressant Medication Management—Effective Acute Phase Treatment* decreased from 2013 to 2014 by 7 percentage points, and the rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators decreased from 2013 to 2015 by 21 and 13 percentage points, respectively.

VA Premier

VA Premier's HEDIS measure results are shown in Table 5-5.

Table 5-5—VA Premier's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	50.33	46.58	49.67*	**48.51**
Childhood Immunization Status				
Combination 2	23.98+	61.59	76.16	**75.18**
Combination 3	20.84+	57.40	72.41	**72.33**
Lead Screening in Children				
Lead Screening in Children	68.70+	70.86	71.52	**70.86**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	0.22	0.66	0.00	**1.46**
One Well-Child Visit	0.44	0.88	1.77	
Two Well-Child Visits	1.99	2.21	1.55	
Three Well-Child Visits	3.75	3.09	5.96	
Four Well-Child Visits	8.61	11.04	7.73	
Five Well-Child Visits	15.45	13.91	13.69	
Six or More Well-Child Visits	69.54	68.21	69.32	**62.86**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.08	71.74	73.73	**71.76**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	49.16	53.68^	52.43	**57.37**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.89	83.66	84.89	**84.30**
Postpartum Care	66.00	62.47	63.33	**62.84**
Care for Chronic Conditions				
Cholesterol Management for Patients With Cardiovascular Conditions				
LDL-C Control (<100 mg/dL)	45.70	42.38	—	—
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	84.30	85.32	86.20	**83.88**
HbA1c Control (<8.0%)	48.17	44.04	49.46	**46.43**
Eye Exam (Retinal) Performed	55.18	55.05	53.64	**54.14**
LDL-C Screening	74.70	74.62	—	—
LDL-C Control (<100 mg/dL)	34.30	37.46	—	—

Table 5-5—VA Premier's HEDIS Measure Results				
	HEDIS 2013 Rate (CY2012)	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Blood Pressure Control (<140/90 mm Hg)	57.16	50.76	61.86	**61.31**
Controlling High Blood Pressure				
Controlling High Blood Pressure	50.99	52.34	59.47	**56.46**
Use of Appropriate Medications for People with Asthma				
5–11 Years	89.92	89.30	89.88	**91.11**
12–18 Years	85.79	84.26	83.95	**87.31**
19–50 Years	68.34	63.69	65.61	**75.83**
51–64 Years	71.32	64.15	60.29	**71.63**
Total	84.59	82.30	82.01	**84.96**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	56.17	52.53	51.29	**49.66**
Effective Continuation Phase Treatment	42.81	36.82	35.89	**33.93**
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	38.58	29.96	41.56	**42.30**
30-Day Follow-Up	65.50	56.77	66.44	**64.63**

[1] 2014 NCQA Quality Compass 50th percentile values are provided for informational purposes. Gray-shaded boxes are displayed for measures where comparisons to the benchmark were not appropriate. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.

[2] A lower rate indicates better performance for this measure.

** Indicates this measure rate was modified and resubmitted as a result of the performance measure validation activity performed by HSAG. The rate in this table is the original rate included in the auditor-locked IDSS file. The HSAG-validated rate is presented below within the Performance Measure Validation Findings section.*

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the 2013 NCQA Quality Compass 50th percentile. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

+ Indicates the measure rate was reported using the auditor-locked IDSS file; however, this rate was reported differently in the 2014 Annual Technical Report using rates reported directly to DMAS.

— Indicates the measure was retired and was not included in HEDIS 2015 reporting; therefore, the HEDIS 2015 rate and corresponding NCQA Quality Compass 50th percentile value are not presented.

Indicates the rate was at or above the corresponding Quality Compass 50th percentile (e.g., HEDIS 2015 Rate [CY2014] was at or above the 2014 NCQA Quality Compass 50th percentile).

VA Premier's Children's Preventive Care measure rates met or exceeded the Quality Compass 50th percentiles for all seven measure indicators with benchmarks in 2015. VA Premier's rates consistently met or exceeded the Quality Compass 50th percentiles for the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits* measure indicators from 2013 to 2015. Further, the rate for *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* decreased to 0 percent in 2015, indicating perfect performance. Also, although performance in the area of childhood immunizations was low in 2013, rates for the *Childhood Immunization Status—*

Combination 2 and *Combination 3* measure indicators improved by over 50 percentage points from 2013 to 2015.

For the Women's Health measure set, rates for two of the three measures met or exceeded the Quality Compass 50th percentiles in 2015, including the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators. VA Premier also met or exceeded the Quality Compass 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator in 2013.

As part of the Care for Chronic Conditions measure set, VA Premier's rates met or exceeded the Quality Compass 50th percentiles for four of the 10 measures with benchmarks in 2015, including *Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, CDC—HbA1c Control (<8.0%), CDC—Blood Pressure Control (<140/90 mm Hg),* and *Controlling High Blood Pressure.* VA Premier's rate for the *CDC—HbA1c Testing* measure indicator consistently met or exceeded the Quality Compass 50th percentiles from 2013 to 2015.

VA Premier's rate for the *CDC—Blood Pressure Control (<140/90 mm Hg)* measure indicator decreased 6 percentage points from 2013 to 2014; however, performance improved by 11 percentage points from 2014 to 2015, which moved the rate into closer alignment with VA Premier's 2013 performance rate and also met or exceeded the Quality Compass 50th percentile. The rates for *Controlling High Blood Pressure* consistently improved each year, resulting in an increase of more than 8 percentage points from 2013 to 2015. Conversely, measure rates for the *Use of Appropriate Medications for People with Asthma—51–64 Years* indicator consistently declined each year, resulting in a decrease of 11 percentage points from 2013 to 2015. Also, VA Premier's 2015 rates for the *Use of Appropriate Medications for People with Asthma—19–50 Years* and *51–64 Years* indicators were 10 and 11 percentage points below the Quality Compass 50th percentiles, respectively.

For the Behavioral Health measure set, rates for three of the four measures met or exceeded the Quality Compass 50th percentiles in 2015, including the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicators. VA Premier's rates consistently met or exceeded the Quality Compass 50th percentiles for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* from 2013 to 2015; however, performance declined annually from 2013 to 2015. VA Premier's performance with regard to follow-up after hospitalization for mental illness fluctuated each year. Specifically, rates indicated a decline in performance from 2013 to 2014 for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, with a decrease of more than 9 percentage points; but performance improved from 2014 to 2015, with an increase of 12 percentage points. Further, the rate for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* decreased by 9 percentage points from 2013 to 2014, and subsequently increased by 10 percentage points from 2014 to 2015.

MCO Comparative and Virginia Aggregate HEDIS Measure Results

Table 5-6 displays, by MCO, the HEDIS measure results compared to the 2014 NCQA Quality Compass 50th percentiles and the Virginia aggregate, which represents the average of all five MCOs' rates weighted by the eligible population. Yellow-shaded boxes indicate MCO rates that were at or above the Quality Compass 50th percentiles, and gray-shaded boxes are displayed for measures for which comparisons to the benchmark were not appropriate. Rates scoring above the Virginia aggregates are represented in green font. Certain measures are not appropriate for comparisons to benchmarks (i.e., *Well-Child Visits in the First 15 Months of Life—One, Two, Three, Four, and Five Well-Child Visits* indicators). Therefore, rates presented for these measures were not compared to Quality Compass 50th percentiles, and the Virginia aggregate values were excluded from the tables and are denoted with gray shading.

Table 5-6—MCO Comparative and Virginia Weighted Aggregate HEDIS Measure Results

	Anthem	Coventry	INTotal	Optima	VA Premier	Virginia Aggregate
Children's Preventive Care						
Adolescent Well-Care Visits						
Adolescent Well-Care Visits	**53.24**	**50.85***	42.26*	46.53*	49.67*	**50.00**
Childhood Immunization Status						
Combination 2	**76.85**	65.69	**75.43**	70.60	**76.16**	**74.39**
Combination 3	**72.45**	60.58	**71.78**	65.97	**72.41**	**70.12**
Lead Screening in Children						
Lead Screening in Children	58.80	**71.29**	**67.40**	**71.59**	**71.52**	**66.53**
Well-Child Visits in the First 15 Months of Life						
No Well-Child Visits[1]	2.13	**1.02**	2.30	**0.56**	**0.00**	**1.04**
One Well-Child Visit	0.80	1.53	0.51	1.39	1.77	
Two Well-Child Visits	0.80	2.55	2.04	2.22	1.55	
Three Well-Child Visits	3.46	4.34	3.83	3.33	5.96	
Four Well-Child Visits	9.31	10.46	11.22	6.94	7.73	
Five Well-Child Visits	18.88	18.11	18.37	15.00	13.69	
Six or More Well-Child Visits	64.63	61.99	61.73	**70.56**	**69.32**	**67.28**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**77.08**	68.85	**78.69**	71.39	73.73	**74.65**
Women's Health						
Breast Cancer Screening						
Breast Cancer Screening	**53.71**	**53.80**	45.11	**55.87**	52.43	**53.26**
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	**86.18**	**85.64**	72.02	75.29	**84.89**	**82.17**
Postpartum Care	**63.47**	**64.89**	52.55	58.28	**63.33**	**61.48**

Table 5-6—MCO Comparative and Virginia Weighted Aggregate HEDIS Measure Results						
	Anthem	Coventry	INTotal	Optima	VA Premier	Virginia Aggregate
Care for Chronic Conditions						
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	83.95	83.21	**85.89**	84.95	**86.20**	**84.99**
HbA1c Control (<8.0%)	**50.93**	48.42	46.96	**53.70**	49.46	**50.73**
Eye Exam (Retinal) Performed	46.51	**54.26**	45.26	45.83	**53.64**	**48.98**
Blood Pressure Control (<140/90 mm Hg)	**61.63**	58.15	59.12	56.71	**61.86**	**60.10**
Controlling High Blood Pressure						
Controlling High Blood Pressure	**58.24**	**58.56**	55.50	48.72	**59.47**	**56.03**
Use of Appropriate Medications for People with Asthma						
5–11 Years	**90.30**	88.59	88.97	**91.28**	89.88	**90.25**
12–18 Years	84.57	**85.44**	82.35	**86.89**	83.95	**84.92**
19–50 Years	63.60	66.37	67.06	**73.71**	65.61	**67.21**
51–64 Years	64.32	51.35	**71.88**	**75.64**	60.29	**65.43**
Total	83.64	82.00	82.79	**86.29**	82.01	**83.67**
Behavioral Health						
Antidepressant Medication Management						
Effective Acute Phase Treatment	**50.03**	46.71	48.31	46.39	**51.29**	**49.18**
Effective Continuation Phase Treatment	**36.81**	29.25	33.11	33.38	**35.89**	**34.94**
Follow-Up After Hospitalization for Mental Illness						
7-Day Follow-Up	31.42	28.95	22.78	**38.73**	**41.56**	**35.81**
30-Day Follow-Up	60.09	54.79	48.26	**63.66**	**66.44**	**62.09**

** Indicates this measure rate was modified and resubmitted as a result of the performance measure validation activity performed by HSAG. The rate in this table is the original rate included in the auditor-locked IDSS file. The HSAG-validated rate is presented below within the Performance Measure Validation Findings section.*

[1] A lower rate indicates better performance for this measure.

Note: *MCO measure rates scoring above the Virginia aggregate are represented in* ***green****.*

Indicates the rate was at or above the 2014 NCQA Quality Compass 50th percentile.

Among the five MCOs, VA Premier performed best on measures in the Children's Preventive Care measure set as rates for five of the seven measures met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates. Also, for the remaining two measures in this measure set, VA Premier met or exceeded the Quality Compass 50th percentiles. Anthem met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for four measures, and Coventry and Optima both met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for three measures. Of note, Coventry's rate for the *Childhood Immunization Status—Combination 3* indicator was approximately 10 percentage points below the Virginia aggregate rate.

INTotal only met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for two measures.

Within the Women's Health measure set, Anthem, Coventry, and VA Premier performed similarly as all three MCOs met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for two of the three measures in this area. Also, for the remaining measure in this measure set, Anthem and Coventry both exceeded the Virginia aggregate rate. Optima exceeded the Virginia aggregate rate for one measure, but neither Optima nor INTotal met or exceeded the Quality Compass 50th percentiles for the three Women's Health measures. Further, INTotal's rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator was 10 percentage points below the Virginia aggregate rate. Notably, none of the MCOs met the Quality Compass 50th percentile for the *Breast Cancer Screening* measure.

For the Care for Chronic Conditions measure set, Optima's rates for four of the 10 measure indicators were at or above the Quality Compass 50th percentiles and the Virginia aggregate rates. Similarly, Anthem and VA Premier met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for three measures, and both Coventry and INTotal met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for two measures. Notably, all five MCOs met or exceeded the Quality Compass 50th percentile for the *Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%)* measure. None of the MCOs met the Quality Compass 50th percentiles for the *Use of Appropriate Medications for People with Asthma—12–18 Years* and *19–50 Years* measure indicators. For the *Use of Appropriate Medications for People with Asthma—51–64 Years* measure indicator, Optima performed 10 percentage points above and Coventry performed 14 percentage points below the Virginia aggregate rate.

For the Behavioral Health measure set, VA Premier met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for three measures, and Anthem met or exceeded the Quality Compass 50th percentiles and the Virginia aggregate rates for two measures. Optima's rates exceeded the Virginia aggregate rates for two measure indicators; however, Optima did not meet or exceed the Quality Compass 50th percentiles for any of the measures in this measure set. Similarly, neither Coventry nor INTotal met or exceeded the Quality Compass 50th percentiles or the Virginia aggregate rates for any of the measures. Further, INTotal's rates for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators fell approximately 13 and 14 percentage points below the Virginia aggregate rates, respectively. Also, none of the MCOs met or exceeded the Quality Compass 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator.

Performance Measure Validation Findings

Summary of PMV Process

Validation of performance measures is one of three mandatory EQR activities required by the Balanced Budget Act of 1997 (BBA) described at 42 CFR §438.358(b)(2). The purpose of PMV is to assess the accuracy of performance measure rates reported by MCOs and to determine the extent to

which performance measures calculated by the MCOs follow state specifications and reporting requirements.

To meet PMV requirements, DMAS contracted with HSAG to conduct the PMV for the six MCOs, validating the data collection and reporting processes used to calculate the performance measure rates. HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures. HSAG validated a set of performance measures identified by DMAS that were calculated and reported by the MCOs for their Medicaid and FAMIS populations. HSAG conducted the validation in accordance with CMS' PMV protocol cited above.

HSAG focused on data used for calculating and reporting the performance measures for CY 2015 (January 1, 2014–December 31, 2014) for the HEDIS measures.

This section provides conclusions as to the strengths and areas of opportunity related to the quality, timeliness, and access to care provided by the Commonwealth of Virginia MCOs. Appendix A contains a full description of the methodology HSAG used to validate performance measures.

MCO Comparative HEDIS Measure Results

For the HEDIS measures validated by HSAG, Table 5-7 presents the validated rates for each MCO along with the 2014 NCQA Quality Compass 50th percentile values for comparative purposes.

Table 5-7—MCO Comparative Results for PMV Measures

	HEDIS 2015 HSAG-Validated Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
Adolescent Well-Care Visits		
Anthem	53.24**	48.51
Coventry	49.64	
INTotal	43.80	
Optima	44.68	
VA Premier	49.45	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up		
Anthem	31.42**	42.12
Coventry	28.95**	
INTotal	22.78**	
Optima	38.73**	
VA Premier	41.56**	
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up		
Anthem	60.09**	64.43
Coventry	54.79**	
INTotal	48.26**	
Optima	63.66**	
VA Premier	66.44**	

Table 5-7—MCO Comparative Results for PMV Measures		
	HEDIS 2015 HSAG-Validated Rate (CY2014)	2014 NCQA Quality Compass 50th Percentile[1]
[1] 2014 NCQA Quality Compass 50th percentile values are provided for informational purposes. Current and previous years' NCQA Quality Compass 50th percentiles are provided in Appendix B for reference.		
*** Indicates the MCO produced a rate that was not materially biased and was not required to resubmit a corrected rate following the performance measure validation activity performed by HSAG. Therefore, the HSAG-validated rate presented above is the same as the HEDIS 2015 rate presented in the NCQA HEDIS Compliance Audit Findings section.*		

Following HSAG's PMV activities, the *Adolescent Well-Care Visits* rate decreased by 1.21 percentage points for Coventry, increased by 1.54 percentage points for INTotal, decreased by 1.85 percentage points for Optima, and decreased by 0.22 percentage points for VA Premier. All other rates remained the same.

Prevention Quality Indicator (PQI) #3 Results

HSAG calculated the PQI #3: Diabetes Long-Term Complications Admission Rate (NQF #274) performance measure for CY 2014. The measure steward is the Agency for Healthcare Research and Quality (AHRQ). In accordance with the technical measure specifications, PQI #3 measures the number of admissions with a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified), for members ages 18 years and older. Measure rates were presented as per 1,000 members weighted by months of enrollment in 2014.[5-1]

The measure was calculated for both the total Medicaid managed care population and the diabetic Medicaid managed care population for members 18–65 years of age. Table 5-8 presents the PQI #3 performance measure rates for Virginia and stratified by geographic region, age group, gender, and race category.

Table 5-8—PQI #3 Measure Results[1]		
	Diabetes Long-Term Complications Admission Rate per 1,000	
	Diabetic Medicaid Population	Medicaid Population
Virginia Total Rate		
Virginia Total Rate	9.07	0.98
Rates by Region		
Central Virginia	12.64	1.36
Far Southwest Virginia	5.46	0.75
Halifax	—	—
Northern Virginia	8.11	0.93

[5-1] Agency for Healthcare Quality and Research, *Quality Indicators™ Research Version 5.0, Prevention Quality Indicator #3, Technical Specifications, Diabetes Long-Term Complications Admission Rate*, March 2015, Available at: http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V50/TechSpecs/PQI_03_Diabetes_Long-term_Complications_Admission_Rate.pdf. Accessed on: June 4, 2015.

Table 5-8—PQI #3 Measure Results[1]		
	Diabetes Long-Term Complications Admission Rate per 1,000	
	Diabetic Medicaid Population	Medicaid Population
Lower Southwest Virginia	8.76	0.80
Tidewater	9.26	0.92
Upper Southwest Virginia	12.00	1.27
Unknown	—	—
Rates by Age Group		
18–24	—	—
25–34	6.73	0.32
35–44	9.56	1.12
45–54	10.11	2.39
55–64	8.76	2.94
Rates by Gender		
Male	11.69	1.38
Female	7.98	0.84
Rates by Race Category		
White	8.45	0.92
Black/African American	10.36	1.17
Asian	—	—
Southeast Asian/Pacific Islander	—	—
Hispanic	—	—
More than one race/Other/Unknown	—	—

[1] Results were limited to the total Medicaid managed care population and the diabetic Medicaid managed care population. The benchmarks for this measure are not limited to a Medicaid managed care population; therefore, please use caution when comparing the results above to benchmarks. Additionally, due to limited availability of data for members ages 65 and older, results were calculated for members under age 65.

— Rate was not presented given that the numerator was composed of fewer than 11 cases.

As expected, measure results indicated that the rate of admissions due to diabetes long-term complications was almost 10 times higher for Medicaid managed care members with diabetes than for Medicaid managed care members without any indicators of previous diagnosis of or treatment for diabetes in Virginia. Rates indicated that as age increased, the incidence of admissions due to diabetic complications increased for Medicaid managed care members. Conversely, diabetic Medicaid managed care members ages 55 to 64 had a lower rate of admissions than members ages 35 to 44 and ages 45 to 54. In addition, when evaluating the diabetic and nondiabetic Medicaid managed care members in Virginia, males and individuals of Black/African American race had higher incidences of admissions due to diabetic complications.

Conclusions

- HSAG found that, in general, the MCOs' information systems and processes were compliant with the applicable IS standards and the HEDIS reporting requirements related to the key Virginia Medicaid measures for HEDIS 2015.
- Some of the MCOs had last-minute issues with the timeliness of mapping, generating correct medical record review lists, and submitting quality-checked documentation to the auditors.
- INTotal was unable to report Board certification rates due to limitations with its current provider certification data. The MCO should be encouraged to ensure provider data are complete and reliable since this in turn reflects the plan's ability and effectiveness to manage and maintain its provider network.
- Upon evaluation of the MCOs' HEDIS 2015 performance measure results, three of the five MCOs reported positive performance in the area of Children's Preventive Care. Specifically, for three of the five MCOs, rates were at or above the Quality Compass 50th percentiles for the *Adolescent Well-Care Visits; Childhood Immunization Status—Combination 2; Lead Screening in Children; Well-Child Visits in the First 15 Months of Life—No Well-Child Visits; Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits;* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure indicators. However, measure rates for *Childhood Immunization Status—Combination 3* represented an area for needed improvement.
- Three of the five MCOs also demonstrated positive performance in the Women's Health measure set, with rates that met or exceeded the Quality Compass 50th percentiles for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care*. Conversely, the remaining two MCOs' rates were well below the Quality Compass 50th percentiles for these measure indicators. Further, *Breast Cancer Screening* measure rates indicated opportunity for improvement for all five MCOs.
- Within the Care for Chronic Conditions measure set, documentation of controlling and testing HbA1c levels for members with diabetes was an area of strength. All five MCOs reported positive results for the *Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%)* measure indicator, and four MCOs reported positive results for the *CDC—HbA1c Testing* measure indicator. Conversely, four of the five MCOs' performance indicated opportunities for improvement in the care provided to members with asthma who were appropriately prescribed medication, specifically the *Use of Appropriate Medications for People with Asthma—Total* measure indicator. Additionally, low measure rates for the *CDC—Eye Exam (Retinal) Performed* and *CDC—Blood Pressure Control (<140/90 mm Hg)* measure indicators demonstrated a need for improved access to optometrists and documentation of adequate blood pressure control for members with diabetes.
- Measures in the Behavioral Health measure set showed the most opportunity for improvement for a majority of the MCOs. Specifically, four of the five MCOs' rates were low for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicators. Further, rates for three of the five MCOs were low for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure indicators.

Recommendations

- To ensure timely and accurate mapping, generation of medical record review lists, and submission of quality-checked documentation to HEDIS auditors, it was recommended that additional steps be included in quality control activities to ensure documentation and processes are completed effectively.
- For the MCO that could not report Board certification rates, if this measure is required in the future, the MCO should identify processes to improve the provider certification data.
- HSAG recommends that DMAS continue to hold MCOs accountable for key HEDIS measure set rates and assess performance at or above the Quality Compass 50th percentiles. In future years, HSAG recommends that DMAS examine the option of raising the benchmark at which MCOs' HEDIS measure rates are evaluated if overall performance across MCOs shows marked improvement.
- Given the variation in MCO HEDIS rates within each measure set, HSAG recommends that DMAS facilitate sharing of successful improvement interventions for HEDIS measure rates between MCOs (e.g., engage high-performing MCOs to collect strategies for improving prenatal and postpartum care provided to pregnant members, increasing access to optometrists, and adequate blood pressure control for members with diabetes, and share those strategies with low-performing MCOs as appropriate).
- HSAG recommends that MCOs focus on key HEDIS measures, using small-scale, rapid-cycle intervention testing to assess effectiveness and facilitate spread of successful initiatives.

6. Performance Improvement Projects

Introduction

CMS requires that states, through their contracts with MCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of PIPs is one of three mandatory EQR activities that the BBA requires state Medicaid agencies to perform. As described in 42 CFR §438.240(b)(1), DMAS requires that contracted Medicaid MCOs conduct PIPs in accordance with 42 CFR §438.240(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction.

One of the mandatory EQR activities under the BBA requires DMAS to validate PIPs. To meet this validation requirement, DMAS contracted with HSAG as the EQRO. The BBA requires HSAG to assess each MCO's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients" (42 CFR §438.364[a][2]).

Objectives

PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that an MCO serves. This structure facilitates the documentation and evaluation of improvements in care or services. MCOs conduct PIPs to assess and improve the quality of health care and services provided.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.240(b)(1) and 42 CFR §438.240(d)(1)(1–4), including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of interventions.
- Planning and initiation of activities to increase or sustain improvement.

Further, HSAG's PIP validation process includes heightened scrutiny on:

- Barrier analyses performed by the MCO.
- Interventions planned by the MCOs as a result of barrier analyses.
- Mechanisms put in place by the MCO to track interventions and evaluate the effectiveness of the interventions to improve rates.

HSAG critically evaluated each of these areas. The findings from the outcome-focused evaluation are reflected in the validation scoring for the Implementation and Outcomes stages of each PIP.

Validation Overview

As one of the mandatory EQR activities required under the BBA, HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG's evaluation of the PIP included two key components of the quality improvement process, as follows:

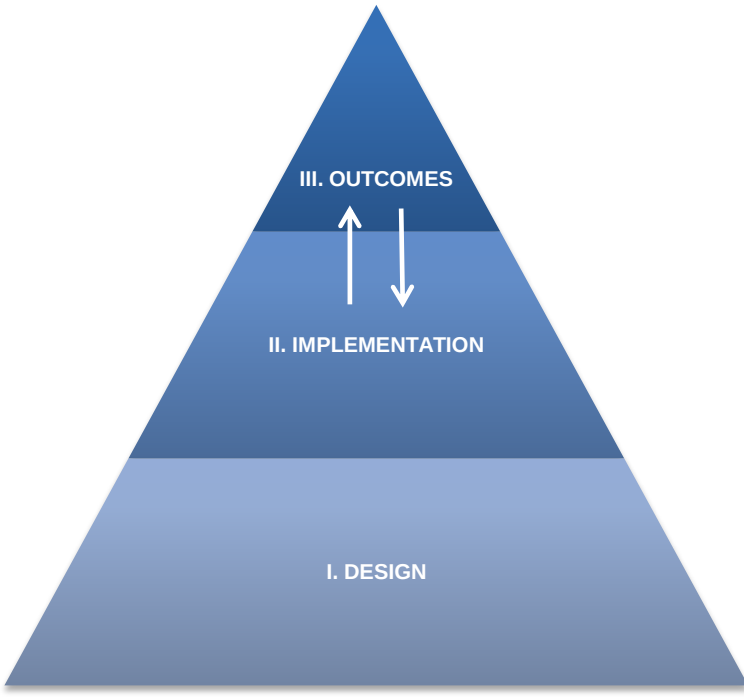
- HSAG evaluated the technical structure of the PIPs to ensure that the MCO designed, conducted, and reported PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determined whether a PIP's design (e.g., study indicators, the data collection methodology, and data analysis plan) was based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- HSAG evaluated the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. This component evaluates how well the MCO improved its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results). The primary goal of HSAG's PIP validation is to ensure that DMAS and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

HSAG obtained the data needed to conduct the PIP validation from the MCO's PIP Summary Forms. These forms provided detailed information about each MCO's PIPs related to the activities completed and that HSAG evaluated for the 2015 validation cycle.

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as *critical* elements. For a PIP to produce valid and reliable results, all *critical* elements had to be *Met*. Given the importance of *critical* elements to the scoring methodology, any *critical* element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. An MCO would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more *critical* elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including *critical* elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a *critical* element percentage score by dividing the total number of *critical* elements scored as *Met* by the sum of the *critical* elements scored as *Met*, *Partially Met*, and *Not Met*. Figure 6-1 illustrates the **three study stages of the PIP process**—i.e., **Design, Implementation, and Outcomes**. Each sequential stage provides the foundation for the next stage. The **Design** stage establishes the methodological framework for the PIP. The activities in this section include development of the study topic, question, indicators, population, sampling, and data collection. To implement successful improvement strategies, a strong design is necessary.

Figure 6-1—PIP Stages



After the MCO establishes its study design, the PIP process moves into the **Implementation** stage. This stage includes data analysis and interventions. During this stage, the MCOs analyze data, identify barriers to performance, and develop interventions targeted to improve outcomes.

The final stage, **Outcomes**, involves the evaluation of real and sustained improvement based on reported results and statistical testing. As the MCO obtains outcomes for the PIP, it should revisit the Implementation stage and expand, standardize, discontinue, revise, or add new interventions as needed. This cyclical process should be used throughout the duration of the PIP and be revisited as often as needed. Sustained improvement is achieved for the PIP when the study indicator(s) demonstrate statistically significant improvement over baseline and sustain the improvement for a subsequent annual measurement period.

Performance Improvement Projects

Follow-Up After Hospitalization for Mental Health Admissions at 7 and 30 Days

The *Follow-up After Hospitalization for Mental Illness* PIP addressed CMS' requirements related to quality outcomes—specifically, timeliness of care and services. The focus of the PIP was to increase the percentages of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and had a follow-up visit within seven and 30 days. These PIPs represent a key area of focus for improvement.

Table 6-1 outlines the study indicators for the *Follow-up After Hospitalization for Mental Illness* PIP.

Table 6-1—Study Indicators	
PIP Topic	**Study Indicators**
Follow-up After Hospitalization for Mental Illness	1. The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within seven days of discharge. 2. The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

Comparative MCO results

This was the fourth year of the *Follow-up After Hospitalization for Mental Illness* PIP and the first year HSAG validated the PIPs as the EQRO for DMAS. The MCOs reported third remeasurement results. The following Table 6-2 provides comparative results across the MCOs for the PIP.

Table 6-2—*Follow-up After Hospitalization for Mental Illness* PIP Results						
MCO	**Follow-Up Results**			**Significant Improvement Over Baseline**	**Sustained Improvement¥**	**Validation Status**
	Measure	**Baseline**	**Remeasurement 3**			
Anthem	7-day	55.43%	31.42%	No	*Not Assessed*	*Met*
	30-day	87.30%	60.09%	No		
Coventry	7-day	46.49%	28.95%	No	*Not Assessed*	*Met*
	30-day	67.03%	54.79%	No		
INTotal	7-day	24.00%	22.78%	No	*Not Assessed*	*Met*
	30-day	47.30%	48.26%	No		
Optima	7-day	57.68%	38.73%	No	*Not Assessed*	*Partially Met*
	30-day	76.78%	63.66%	No		
VA Premier	7-day	38.64%	41.56%	No	*Not Assessed*	*Met*
	30-day	62.41%	66.44%	**Yes**		
¥ To be assessed for sustained improvement, the study indicator results must demonstrate statistically significant improvement over baseline and report a subsequent measurement period result.						

Only one MCO achieved statistically significant improvement over baseline for the *Follow-up After Hospitalization for Mental Illness* PIP—VA Premier, for the 30-day follow-up measure in Remeasurement 3. None of the MCOs were assessed for sustained improvement for this validation. To be assessed for sustained improvement, the study indicator results must demonstrate statistically significant improvement and report a subsequent measurement period result. All of the MCOs achieved a *Met* validation status for the PIP, except Optima, which received a *Partially Met* validation status.

Assessment of overall validity and reliability of study results

The *Follow-up After Hospitalization for Mental Illness* PIPs were based on HEDIS technical specifications. The PIPs were scientifically sound and had solid foundations. The technical design of each PIP was sufficient to measure and monitor outcomes. All of the MCOs included accurate information in the data table and repeated measurements used the same methodology used for the baseline measurement.

HSAG's assessment determined confidence in the results for Anthem, Coventry, INTotal, and VA Premier. HSAG's assessment determined low confidence in the results for Optima's *Follow-up After Hospitalization for Mental Illness* PIP. Optima received a *Met* score for 74 percent of applicable evaluation elements and an overall *Partially Met* validation status.

PIP interventions and outcomes information

The following Table 6-3 includes the barriers and interventions that the MCOs provided for the current reporting period in the *Follow-up After Hospitalization for Mental Illness* PIP.

Table 6-3—*Follow-up After Hospitalization for Mental Illness* PIP Barriers and Interventions

MCO	Barriers	Interventions
Anthem	◆ Lack of adequate and consistent discharge planning. ◆ Lack of referrals. ◆ Transient population. ◆ Appointment availability. ◆ Lack of transportation.	◆ Stabilization case management—education and support to prevent readmission. ◆ Member outreach telephone calls. ◆ Care managers help facilitate follow-up appointments.
Coventry	◆ Provider compliance. ◆ Member compliance.	◆ Case managers documented follow-up visits (initiated in 2013 and terminated in 2015). ◆ Contract with facilities to complete a review of follow-up appointments with members before discharge (initiated in 2013 and terminated in 2015). ◆ Monthly claims reports to identify facilities that did not obtain precertification for inpatient care (initiated in 2013 and terminated in 2015). ◆ Provider committee to build stronger relationships with providers (initiated in 2014 and terminated in 2015). ◆ Provider education (initiated in 2014 and terminated in 2015)
INTotal	◆ Members do not follow up with transportation arrangements. ◆ Members unwilling to commit to aftercare plan. ◆ Members may feel better at discharge and believe follow-up care is not necessary. ◆ Providers unfamiliar with intervention and/or psychiatric medications.	◆ Behavioral health care manager to coordinate care. ◆ Pediatric psychiatrist located in a pediatric clinic.

Table 6-3—*Follow-up After Hospitalization for Mental Illness* PIP Barriers and Interventions		
MCO	**Barriers**	**Interventions**
	◆ Provider concerns with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. ◆ MCO cannot contact members due to incorrect contact information. ◆ Inadequate coordination between MCO case management and hospital discharge planners.	
Optima	◆ Member not fully aware or involved in aftercare plan. ◆ Members see aftercare clinicians who are not licensed and cannot submit claim for service. ◆ Data missed due to coding specifications.	◆ Bridge program (clinician visit) at high-volume facilities. ◆ Member outreach telephone calls.
VA Premier	◆ Lack of coordination between settings. ◆ Lack of member knowledge regarding the mental health disease process. ◆ Lack of provider and member knowledge regarding transportation and care benefits.	◆ Network service representatives conduct follow-up meetings with discharge planners to increase their knowledge of the MCO. ◆ The addition of 865 behavioral health practitioners to the network in 2014 to increase access to care. ◆ Case manager calls the member within seven days of discharge and transportation is arranged, if needed, for members to pick up prescriptions at the pharmacy. ◆ A bridge program for discharge visits and follow-up home health visits.

Adolescent Well-Care Visits

The *Adolescent Well-Care Visits* PIP addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to increase the percentage of members 12 to 21 years of age who have an annual preventive health care visit.

Table 6-4 outlines the study indicator for the *Adolescent Well-Care Visits* PIP.

Table 6-4—Study Indicator	
PIP Topic	**Study Indicator**
Adolescent Well-Care Visits	The percentage of eligible members 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.

Comparative MCO results

This was the fourth year of the *Adolescent Well-Care Visits* PIP and the first year HSAG validated the PIPs as the EQRO for DMAS. The MCOs reported third remeasurement results. The following Table 6-5 provides comparative results across the MCOs for the PIP.

Table 6-5—*Adolescent Well-Care Visits* PIP Results

MCO	Results		Significant Improvement Over Baseline	Sustained Improvement¥	Validation Status
	Baseline	Remeasurement 3			
Anthem	44.21%	53.24%	**Yes**	*Not Assessed*	*Met*
Coventry	48.61%	49.64%	No	*Not Assessed*	*Met*
INTotal	49.10%	46.26%	No	*Not Assessed*	*Met*
Optima∞	47.24% (hybrid)	44.68% (hybrid)	No	*Not Assessed*	*Partially Met*
	33.07% (administrative)	44.18% (administrative)	**Yes**	**Yes**	
VA Premier	44.28%	49.67%	No	*Not Assessed*	*Met*

¥ To be assessed for sustained improvement, the study indicator results must demonstrate statistically significant improvement over baseline and report a subsequent measurement period result.
∞ Optima was the only MCO that reported two study indicators for this PIP.

Anthem and Optima (administrative rate) achieved statistically significant improvement over baseline in the rate of adolescent well-care visits. Only Optima achieved sustained improvement in the administrative rate. To be assessed for sustained improvement, the study indicator results must demonstrate statistically significant improvement over baseline and report a subsequent measurement period result. Anthem did not achieve statistically significant improvement over baseline until Remeasurement 3; therefore, another measurement would be required to assess for sustained improvement. All of the MCOs achieved a *Met* validation status for the PIP, except Optima, which received a *Partially Met* validation status.

Assessment of overall validity and reliability of study results

The *Adolescent Well-Care Visits* PIPs were also based on HEDIS technical specifications. The PIPs were scientifically sound and had solid foundations. The technical design of each PIP was sufficient to measure and monitor outcomes. All of the MCOs' repeated measurements used the same methodology used for the baseline measurement. Anthem, Coventry, INTotal, and VA Premier included accurate information in the PIP submission data table. Optima's HEDIS rate from the IDSS did not match either rate reported by the MCO in the PIP.

For the *Adolescent Well-Care Visits* PIPs, HSAG's assessment determined high confidence in the results for Anthem, Coventry, and VA Premier; confidence in the results for INTotal; and low

confidence in the results for Optima. Optima received a *Met* score for 81 percent of applicable evaluation elements and an overall *Partially Met* validation status.

PIP interventions

The following Table 6-6 includes the barriers and interventions that the MCOs provided for the current reporting period in the *Adolescent Well-Care Visits* PIP.

Table 6-6—*Adolescent Well-Care Visits* PIP Barriers and Interventions

MCO	Barriers	Interventions
Anthem	◆ Member compliance with getting preventive care. ◆ Parental childcare expense/time off work/transportation. ◆ Provider lack of knowledge.	◆ Telephone outreach—assist members in scheduling appointments and transportation. ◆ Provider education office visits. ◆ Clinic days—provider holds open appointments for members needing service. ◆ Member outreach from case management. ◆ Gaps in care reports sent to providers.
Coventry	◆ Provider knowledge and compliance. ◆ Member compliance with obtaining preventive care.	◆ Provider education office visits (terminated in 2013). ◆ Provider $25 incentive (initiated in Quarter 3 2013 and terminated in Quarter 4 2013). ◆ Provider newsletter (terminated in 2014). ◆ Member $25 incentive (initiated in Quarter 3 2013 and terminated in Quarter 4 2013).
INTotal	◆ Transient members. ◆ Transportation. ◆ Parents/guardians do not understand the importance of well-care visits. ◆ Providers not fully documenting the required components of well-care visits. ◆ MCO cannot contact members due to incorrect contact information. ◆ Insufficient data capture.	◆ Member incentive—$25 gift card for completed visits. ◆ Health promotions event. ◆ Member mailings, newsletter, and website included reminders that the yearly preventive exam is free.
Optima	◆ Parents do not understand the importance of well-care visits. ◆ Providers do not document all of the necessary information about the visit in the medical record. ◆ Well-care visits are performed in schools for sports physicals.	◆ Telephonic and letter reminders for members to complete a well-care visit. ◆ Raffle for members to win one of four Kindle Fires. ◆ Provider newsletter article.
VA Premier	◆ Member and provider engagement. ◆ Member and provider knowledge.	◆ Provider pay-for-performance program.

Table 6-6—*Adolescent Well-Care Visits* PIP Barriers and Interventions		
MCO	**Barriers**	**Interventions**
	◆ Access to care.	◆ "Watch Me Grow Program"—periodic screening, diagnosis, and treatment program offered to children of all ages. ◆ "Text4Kids (Connect4health)"—text message reminders. ◆ HEDIS quick reference billing guides for providers. ◆ Close the Loop program—network collaboration.

Conclusions

HSAG organized, aggregated, and analyzed the MCO's PIP data to draw conclusions about the MCO's quality improvement efforts. The PIP validation process evaluated both the technical methods of the PIP (i.e., the design) and the outcomes associated with the implementation of interventions. Based on its technical review, HSAG determined the overall methodological validity of the PIPs.

The following Table 6-7 displays the MCOs' performance in each stage of the process and includes both PIP submissions. The percentages are the applicable evaluation elements that received a *Met* score in each stage.

Table 6-7—PIP Stage			
MCO	**Design**	**Implementation**	**Outcomes**
Anthem	100% (23/23)	100% (16/16)	67% (4/6)
Coventry	100% (23/23)	100% (16/16)	50% (3/6)
INTotal	100% (16/16)	100% (16/16)	33% (2/6)
Optima	96% (22/23)	69% (11/16)	43% (3/7)
VA Premier	100% (23/23)	100% (18/18)	50% (3/6)

Design

All of the MCOs received a *Met* score for 100 percent of the application evaluation elements in the Design stage (Activities I through VI), except Optima. Overall, the PIPs were scientifically sound and had solid foundations. Appropriately documented designs allow for the successful progression to the next phase of the PIPs: Implementation.

Implementation

Anthem, Coventry, INTotal, and VA Premier received a *Met* score for 100 percent of the applicable evaluation elements in the Implementation stage (Activities VII and VIII), indicating that the MCOs completed causal/barrier analysis with a clearly documented team, processes, and quality improvement tools, and that interventions were linked with barriers. The MCOs included accurate and clear information in the data tables and provided a narrative interpretation of the results that included all of the required components for data analysis and statistical testing.

Optima had opportunities for improvement in the Implementation stage for both PIPs. The MCO received a *Met* score for 69 percent of the applicable evaluation elements in Activities VII and VIII. The *Adolescent Well-Care Visits* PIP included rates that did not match the HEDIS IDSS rates, and HSAG was unable to replicate *z* test and *p* values documented in the PIP. For the *Follow-up After Hospitalization for Mental Illness* PIP, Optima did not include a comparison to goals in the narrative interpretation of the results, and HSAG was unable to replicate the *p* values documented in the PIP. The MCO did not provide the quality improvement tools used for causal/barrier analysis for either PIP.

Outcomes

All of the MCOs had opportunities for improvement in the Outcomes stage (Activities IX and X.) The following Table 6-8 includes the opportunities for improvement that HSAG identified in the Outcomes stage for each of the five MCOs.

Table 6-8—Opportunities for Improvement

MCO	*Adolescent Well-Care Visits*	*Follow-up After Hospitalization for Mental Illness*
Anthem	◆ No opportunities for improvement—the study indicator demonstrated improvement that met the goal and statistically significant improvement over baseline.	◆ The study indicators demonstrated declines from Remeasurement 2 to Remeasurement 3 and did not meet the goals. The Remeasurement 3 results were lower than the baseline results.
Coventry	◆ The study indicator demonstrated improvement that met the goal; however, the improvement from baseline to Remeasurement 3 was not statistically significant.	◆ The study indicators have continually declined since Remeasurement 1 and did not meet the goals. The Remeasurement 3 results were lower than the baseline results.
INTotal	◆ The Remeasurement 3 result did not meet the goal and was lower than the baseline.	◆ Neither study indicator demonstrated statistically significant improvement over baseline. Study Indicator 1 demonstrated a decline for Remeasurement 3 and was below the baseline. ◆ Although the Remeasurement 3 result for Study Indicator 2 was nearly 1 percentage point above the baseline, it had continually declined since Remeasurement 1 and did not meet the goal.
Optima	◆ The Remeasurement 3 result for Study Indicator 2 met the goal; however, the	◆ The Remeasurement 3 results did not meet the goals, and both study indicator results were below the baseline results.

Table 6-8—Opportunities for Improvement		
MCO	***Adolescent Well-Care Visits***	***Follow-up After Hospitalization for Mental Illness***
	result for Study Indicator 1 did not meet the goal. ◆ Study Indicator 2 demonstrated statistically significant improvement over baseline; however, the rate for Study Indicator 1 declined and was lower than the baseline.	
VA Premier	◆ The study indicator demonstrated improvement that met the goal; however, the improvement over baseline was not statistically significant.	◆ Study Indicator 1 did not meet the goal, while Study Indicator 2 surpassed the goal. ◆ Study Indicator 2 achieved statistically significant improvement over baseline; however, Study Indicator 1 did not achieve statistically significant improvement over baseline.

Recommendations

The PIPs were methodologically sound projects; however, the Outcomes stage represented an opportunity for improvement for all MCOs. The Outcomes stage is the culmination of the previous two stages of the PIP. When improved PIP outcomes are not achieved, it is necessary for MCOs to revisit steps in the Implementation stage, including the identification of barriers through barrier analysis and the subsequent selection of effective improvement strategies to address them.

In addition, the MCOs' choice of interventions, combination of intervention types, sequence, and timing of interventions are essential to the PIP's overall success. Active interventions (e.g., system changes, direct member and/or provider contact, events, incentives) should be selected instead of passive changes (e.g., newsletters, postcard mailings, Interactive Voice Response [IVR] calls, website updates). Passive interventions can be difficult to evaluate because it is unclear whether the member or provider was reached and/or the change had any impact on the study indicator result.

The MCOs should also regularly evaluate interventions to ensure they are having the desired effect. A concurrent review of data is encouraged. HSAG recommends rapid-cycle testing of interventions on a small scale using a quality improvement method such as Plan-Do-Study-Act (PDSA). Interventions that are deemed effective when tested on a small scale should be considered and evaluated for larger-scale testing. If the evaluation of interventions, and/or review of data, indicates that interventions are not having a desired effect, the MCOs should revisit causal/barrier analysis; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

HSAG recommends that the MCOs:

- Conduct causal/barrier analysis using quality improvement tools (e.g., a key driver diagram, fishbone diagram, or process mapping) for each PIP topic at least annually and ensure that the

quality improvement tools completed focus specifically on barriers to improving the study indicator results for the PIP topic.

- Drill down to determine why the members and providers are "not compliant." The reasons why would be the barriers.
- Prioritize barriers for all PIPs based on results of data analysis and/or other quality improvement processes.
- Implement active interventions to address the highest-priority barriers.
- Logically link all interventions with barriers that were identified as a result of causal/barrier analysis.
- Have an evaluation plan to measure the effectiveness of each intervention.
- Review interim intervention evaluation results and make modifications to interventions as necessary.
- Be cognizant of the timing of interventions. Interventions implemented too late in the measurement period will not have enough time to impact the results. Each remeasurement period should have active interventions that are in place throughout the entire measurement period.
- Evaluate if there are additional system and/or process barriers impeding improvement and identify evidence-based interventions that can be implemented to address the barriers.
- Consider testing more changes on a small scale using rapid-cycle quality improvement tools such as PDSA.

Improving Birth Outcomes Through Adequate Prenatal Care

Objectives

HSAG worked with DMAS to develop a birth outcomes focused study that will provide quantitative information about prenatal care and associated birth outcomes among Medicaid recipients (including women enrolled in the Medicaid for Pregnant Women and FAMIS MOMS programs) for all singleton births paid by Virginia Medicaid during CY 2014. Previously published CY 2012 and CY 2013 birth outcomes results will be reported with the current study for informational purposes. This study will address the following questions:

- *To what extent do women with births paid by Medicaid receive early and adequate prenatal care?*
- *What clinical outcomes are associated with Medicaid-paid births?*

DMAS approved the study methodology during Contract Year One, and HSAG will submit final results for this study to DMAS in March 2016. The complete study methodology is available in Appendix C.

Description of Data to Be Obtained

HSAG used Medicaid recipient, claims, and encounter data files supplied by DMAS to identify members eligible for the study and submitted this list to VDH. VDH used probabilistic data linking to match HSAG's list of members eligible for the study to birth registry records. In addition to the probabilistic data linkage, VDH matched HSAG's list of study-eligible members to birth registry records using social security numbers. VDH returned a data file to HSAG containing the information from HSAG's original list and all birth registry data fields for matching members for each of the data linkage processes.

Description of Planned Data Collection and Analysis

HSAG identified study-eligible members from all probabilistically linked or deterministically linked birth registry records, and both birth registry records and Medicaid claims and encounter data files are being used to calculate study indicators and identify stratification categories. Births will be grouped into a study population and a comparison group, based on the timing and length of Medicaid enrollment. The study population will include women continuously enrolled in the FAMIS MOMS, the Medicaid for Pregnant Women, or an "Other Medicaid" program for a minimum of 43 days prior to, and including, the date of delivery. The "Other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women categories.

The comparison group will include women enrolled in one of the three Medicaid program groups defined above on the date of delivery, but without prior continuous enrollment.

Five study indicators will be calculated for all study-eligible members:

- Percentage of births with early and adequate prenatal care
- Percentage of births by gestational estimate
- Percentage of newborns with low birth weight
- Percentage of newborns receiving at least two visits with a primary care provider (PCP) in the 30 days following birth
- Percentage of newborns who had at least one emergency department (ED) visit in the 30 days following birth

Indicator results will be stratified by study and comparison groups, program, benefit program and delivery system, and demographic categories (e.g., maternal age, maternal race/ethnicity).

Improving the Health of Children in Foster Care

Objectives

HSAG worked with DMAS to develop a foster care focused study that will provide quantitative and qualitative information about foster care children receiving medical services through Medicaid managed care plans (MCPs). The study will address the following question: *To what extent did children in foster care receive the expected preventive and therapeutic medical care in the first year of managed care service delivery*?

The study will examine services received by foster care children younger than 18 years of age from July 1, 2014, through June 30, 2015 (i.e., the first full year of statewide managed care service delivery for these members). The study will occur during Contract Years One and Two, and DMAS approved the study methodology and medical record procurement materials during Contract Year One. HSAG will submit final study results to DMAS in September 2016. The complete study methodology is available in Appendix D.

Description of Data to Be Obtained

HSAG will use Medicaid recipient, claims, and encounter data files supplied by DMAS to identify the study population and calculate study indicators based on administrative data. HSAG will also calculate two hybrid study indicators based on information abstracted from a statistically valid sample of medical records. Once the sample is identified, HSAG will work directly with providers to locate and collect medical records for these cases. Upon receipt of the medical records, HSAG's clinical review staff will abstract the information from the medical records using an electronic data collection instrument specific to the study indicators for the well-child and immunization measures.

Description of Planned Data Collection and Analysis

HSAG will use administrative and medical record data for the study population to calculate study indicators across three categories:

- Characteristics of Medicaid Members in Foster Care (five indicators)
- Preventive Care (four indicators)
- Behavioral Health (six indicators)

Since this population was newly enrolled into managed care service delivery, HSAG will identify all children enrolled in the foster care aid category at any point during the measurement period for the eligible study population. Calculation of study indicators for health care quality and utilization will be limited to children meeting continuous enrollment specifications within managed care service delivery.

Health and Acute Care Program

Objectives

HSAG worked with DMAS to develop a Health and Acute Care Program (HAP) focused study that will provide quantitative information about the clinical profile of Medicaid Medallion 3.0 members in HAP. Beginning on December 1, 2014, the fee-for-service delivery system for members covered by one of five waiver programs was transitioned to the managed care delivery system via the Medallion 3.0 contract. The study will address the following question: *To what extent did HAP members in this combined waiver population use medical and pharmacy services during the first year of managed care coverage?*

DMAS approved the study methodology during Contract Year One to include two phases of analysis, with the first phase assessing HAP members' service utilization in the year prior to December 1, 2014, and the second phase assessing utilization from December 1, 2014, through November 30, 2015. HSAG will submit results for study phase 1 in January 2016 and final results for both study phases in September 2016. The complete study methodology is available in Appendix E.

Description of Data to Be Obtained

The eligible population consists of all Medicaid members enrolled in HAP as of December 1, 2014. HSAG used monthly enrollment files supplied by DMAS and extracted on the first day of each month in the study period to identify members eligible for the study. The eligibility of HAP members identified in the December 1, 2014, enrollment file was based on enrollment records at a point in time and did not capture eligibility segments, or consequently, continuous enrollment.

In addition to administrative and encounter data, DMAS supplied HSAG with dental encounter data from the Medicaid Dental Benefit Manager (DBM), DentaQuest, and behavioral health encounter data from Magellan. Data extraction for Phase II analyses (December 1, 2014, through November 30, 2015) will begin no earlier than April 1, 2016. DMAS has already provided HSAG with data for

Phase I (December 1, 2013, through November 30, 2014) analyses in the course of other EQR activities.

Description of Planned Data Collection and Analysis

HSAG will establish an analytic dataset containing a member-level profile of members' demographic, clinical, and utilization characteristics (i.e., study metrics). This information will then be aggregated statewide (i.e., at the HAP level) and by individual waiver program for each of the two periods under consideration. The study metrics are grouped into three domains:

- Demographic (seven measures)
- Clinical (three measures)
- Utilization (divided between medical and pharmacy-related metrics)
  - Medical (five measures)
  - Pharmacy (five measures)

HSAG will assemble these study metrics for each member in the study population and compare the aggregated statewide and program results across both study phases.

8. Encounter Data Validation

Objectives

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DMAS requires the contracted MCOs to submit high-quality encounter data. For the contract year 2015–2016, DMAS contracted with HSAG to conduct an EDV study. The goal of the EDV study is to assist DMAS staff in developing an encounter data program that effectively monitors the completeness and accuracy of encounter data on an ongoing basis, including development of a manageable set of processes that can be implemented and maintained at the State and MCO levels.

Description of Data Collection and Analysis

Data collection for this EDV study was conducted using the approved scope of work that included monthly technical assistance conference calls targeted to a specific area or process and the associated policies and procedures surrounding the collection, monitoring, and ongoing improvement of encounter data. HSAG performed an administrative analysis to assist DMAS with setting up the encounter data standards for future MCO contracts, and this baseline assessment will be presented at the MCO and statewide levels. In order to conduct the administrative analysis, HSAG worked with DMAS to receive extracts from its Medicaid Management Information System (MMIS). HSAG required encounter data for dates of service between July 1, 2013, and December 31, 2014, and DMAS provided the monthly SAS®[8-1] data from MMIS for data through June 2015.

Summary of 2015 EDV Activity and Activities to Be Completed in 2016

To successfully complete this project, HSAG collaborated with key DMAS staff to conduct the following key activities:

- **Task 1—Encounter Data Protocol Review:** HSAG reviewed and discussed the existing protocols and procedures for the submission, collection, processing, management, and monitoring of encounter data via monthly conference calls with key stakeholders from DMAS to identify gaps in current encounter data quality programs and target priority areas for review and improvement.
- **Task 2—Technical Assistance (TA) Related to Monitoring/Reporting Strategies:** Drawing on information obtained from the monthly conference calls, baseline encounter data quality results, and the MCO-Specific Encounter Data Quality (EDQ) reports from the new EDQ process, HSAG will assist DMAS in (1) improving/updating the existing critical issues in the Managed Care Technical Manual, (2) evaluating the emerging issues in the Managed Care

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Technical Manual and potentially updating/promoting specific issues to critical issues, and (3) identifying existing data quality deficits and recommending areas/mechanisms for improvement.

- **Task 3—Assessment of Encounter Data Accuracy, Completeness, and Timeliness:** The analysis of encounter data completeness, accuracy, and timeliness involved calculation of evaluation metrics at the file and/or field level using the most recent encounter data extracted from DMAS' MMIS. These evaluations were conducted to supplement DMAS' ongoing EDQ program reporting by expanding its analysis in order to (1) investigate findings from monitoring reports, and (2) further assist with the development of encounter data standards suitable for Virginia's Medallion 3.0 program.

Upon the completion of this study, HSAG will submit one aggregate report to DMAS containing key findings and recommendations from all three tasks, with MCO-specific results in an appendix. The MCO-specific appendix will provide the results from the assessment of encounter data accuracy, completeness, and timeliness for a specific MCO and the statewide results, and can be distributed to each MCO for further investigation. The report will also provide recommendations that are specific and actionable. The final aggregate report will be delivered to DMAS on or before January 31, 2016.

9. Consumer Survey of Quality of Care

Introduction

This section of the report includes a summary assessment of the FAMIS program and MCOs' strengths and opportunities for improvement derived from the results of CAHPS survey activities. Also included are HSAG's conclusions and general recommendations for improving on the CAHPS survey measure domains. The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences.

The CAHPS surveys ask members and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

DMAS contracted with HSAG to administer and report the results of the CAHPS survey for the statewide FAMIS program. Anthem, Coventry, INTotal, Optima, and VA Premier were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf for Medicaid managed care. The MCOs' CAHPS results were forwarded to HSAG for purposes of inclusion in this report. Within this section, the statewide FAMIS program's results are presented followed by those of the Medallion 3.0 MCOs. The Medallion 3.0 CAHPS results are presented for the statewide aggregate and each MCO for the adult and child Medicaid managed care populations, respectively.

FAMIS CAHPS

Methods of Data Collection and Analysis

For the FAMIS program, the technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions measurement set. In accordance with CMS' Children's Health Insurance Program Reauthorization Act (CHIPRA) CAHPS reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members receiving health care services through FFS or managed care, representative of the entire population of children covered by Virginia's Title XXI program (i.e., Children's Health Insurance Program [CHIP] members in FFS or managed care).

A mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys) was used for the FAMIS program. Parents or caretakers of child members completed the surveys between the time period of March to June 2015, and had the option to complete the survey in English or Spanish.

The CAHPS 5.0 Child Medicaid Health Plan Survey (with the Children with Chronic Conditions measurement set) administered to FAMIS members includes a set of 83 standardized items that assess patient perspectives on care. The survey questions were categorized into 14 measures of satisfaction.[9-1] These measures included four global ratings, five composite measures, and five Children with Chronic Conditions composites and items.[9-2] The global ratings reflected members' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The Children with Chronic Conditions composite and item measures are derived from sets of questions and individual questions that address aspects of care for children with chronic conditions.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). For each of the composite scores and individual items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A positive or top-box response for the composites and items was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores and question summary rate for the individual item scores.

For the FAMIS program, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, the FAMIS program's scores were compared to 2014 NCQA CAHPS child Medicaid national averages, where applicable.[9-3,9-4] A measure was noted when the measure's rate was at least 5 percentage points higher or lower than the NCQA national average.

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

9-1 For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings, five composite measures, and five Children with Chronic Conditions CAHPS measures.

9-2 The Children with Chronic Condition composite and items measures are applicable to the population of children with chronic conditions only; therefore, these measures are not reported for the general child population.

9-3 Quality Compass 2014 data serve as the source for the 2014 NCQA CAHPS child Medicaid national averages for the general child and children with chronic conditions populations (i.e., general child and children with chronic conditions results).

9-4 With the release of the 2015 CAHPS 5.0 Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure. As a result of these changes, comparisons to the 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015.

Following the administration of the CAHPS 5.0 Child Medicaid Health Plan Surveys to the FAMIS program, HSAG provided DMAS with an aggregate report of the general child and children with chronic condition CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program child members enrolled in FFS and managed care combined).

For additional detail on the CAHPS survey methodology, please refer to Appendix G of this report.

FAMIS Program Aggregate Results

In 2015, a total of 3,490 FAMIS members were surveyed and 1,095 parents/caretakers returned a completed survey on behalf of a child member.[9-5] After ineligible members were excluded, the response rate for the FAMIS program was 32.0 percent. The FAMIS program's response rate was greater than the national child Medicaid response rate reported by NCQA for 2015, which was 28.5 percent.

Table 9-1 shows the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) for each global rating and composite measure, respectively, for the FAMIS program's general child population.

Table 9-1—FAMIS Program General Child CAHPS Results

Measure	2015 Rate
Global Ratings	
Rating of Health Plan	65.2%
Rating of All Health Care	67.4%
Rating of Personal Doctor	72.5%
Rating of Specialist Seen Most Often	68.4%+
Composite Measures	
Getting Needed Care	82.9%
Getting Care Quickly	84.1%
How Well Doctors Communicate	91.1%
Customer Service	85.8%
Shared Decision Making	75.6%+

+ The program had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Due to changes to the Shared Decision Making composite, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.

Cells highlighted in yellow represent rates that are equal to or greater than the 2014 NCQA national child Medicaid average.

[9-5] The total number of members surveyed, completed surveys, and response rate are based on the responses of parents/caretakers of children in the general child and children with chronic conditions supplemental populations.

Comparison of the FAMIS program's 2015 general child CAHPS results to 2014 NCQA national child Medicaid averages revealed the following summary results:

- The FAMIS program scored at or above the 2014 NCQA national child Medicaid average on one measure, *Rating of All Health Care*.
- The FAMIS program scored 5 or more percentage points lower than the 2014 NCQA national child Medicaid average on one measure, *Getting Care Quickly*.

Table 9-2 shows the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) for each global rating, composite measure, and children with chronic condition composite and item for the FAMIS program's children with chronic conditions population.

Table 9-2—FAMIS Program
Children With Chronic Conditions CAHPS Results

Measure	2015 Rate
Global Ratings	
Rating of Health Plan	59.9%
Rating of All Health Care	61.5%
Rating of Personal Doctor	69.7%
Rating of Specialist Seen Most Often	70.3%
Composite Measures	
Getting Needed Care	85.8%
Getting Care Quickly	90.3%
How Well Doctors Communicate	91.7%
Customer Service	81.4%+
Shared Decision Making	78.8%
Children With Chronic Conditions Composites and Items	
Access to Specialized Services	76.7%+
Family-Centered Care (FCC): Personal Doctor Who Knows Child	88.7%
Coordination of Care for Children with Chronic Conditions	74.1%+
FCC: Getting Needed Information	87.8%
Access to Prescription Medicines	90.4%

+ The program had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Due to changes to the Shared Decision Making composite, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.

Cells highlighted in yellow represent rates that are equal to or greater than the 2014 NCQA national child Medicaid average.

Comparison of the FAMIS program's 2015 children with chronic conditions CAHPS results to 2014 NCQA national child Medicaid averages for children with chronic conditions revealed the following summary results:

- The FAMIS program scored at or above the 2014 NCQA national child Medicaid average on one measure, *Rating of Specialist Seen Most Often*.
- The FAMIS Program scored 5 or more percentage points lower than the 2014 NCQA national child Medicaid average on two measures: *Rating of Health Plan* and *Customer Service*.

Medallion 3.0 CAHPS

Methods of Data Collection and Analysis

For the Medallion 3.0 MCOs, Anthem, Coventry, INTotal, Optima, and VA Premier, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[9-6] The mode of CAHPS survey data collection varied slightly among the MCOs. Anthem, Coventry, and VA Premier each used a standard Internet mixed-mode methodology, while INTotal used a mixed-mode methodology of data collection. Optima used a standard Internet mixed-mode methodology of data collection for its adult Medicaid members and a standard mixed-mode methodology for its child Medicaid members. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2015.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[9-7] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) for purposes of reporting.

9-6 VA Premier administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set to its child Medicaid population, while the other MCOs administered the CAHPS 5.0 Child Survey without the chronic conditions measurement set. For purposes of this report, the child Medicaid CAHPS results presented for VA Premier represent the CAHPS results for its general child population (i.e., general child CAHPS results).

9-7 Anthem contracted with DSS Research, Coventry contracted with the Center for the Study of Services (CSS), INTotal contracted with MORPACE, and Optima and VA Premier both contracted with SPH Analytics (formerly The Myers Group) to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations.

The CAHPS 5.0H Surveys include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into nine measures of satisfaction.[9-8] These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For Medallion 3.0, the statewide aggregate score and each MCO's scores were compared to 2014 NCQA national Medicaid averages, where applicable.[9-9,9-10] For purposes of this comparison, a measure was noted when the measure's rate was at least 5 percentage points higher or lower than the 2014 NCQA national average. Additionally, HSAG compared the MCOs' CAHPS survey results to identify those measures for which MCOs scored highest and lowest. The MCO comparisons were performed for each the four CAHPS global ratings and five composite measures.

It is important to note that NCQA requires a minimum of 100 respondents in order to report the CAHPS item as a valid survey result. If the NCQA minimum reporting threshold of 100 respondents was not met, the CAHPS score was denoted as Not Applicable (NA).

Description of Data Obtained

As described above, the CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated (adult population only).

[9-8] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings and five composite measures.

[9-9] With the release of the 2015 CAHPS 5.0 Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure. As a result of these changes, comparisons to the 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015.

[9-10] Quality Compass 2014 data serve as the source for the 2014 NCQA CAHPS adult Medicaid and child Medicaid national averages.

Ineligible members were identified during the survey process. This information was recorded by the MCOs' survey vendors, and a summary of the final survey dispositions was provided to HSAG in the data (i.e., NCQA Summary Reports) received.

For additional detail on the CAHPS survey methodology, please refer to Appendix G of this report.

Aggregate and Comparative MCO Results

Adult Medicaid CAHPS Results

Table 9-3 presents the 2015 adult Medicaid CAHPS top-box scores (e.g., the percentage of top-level responses) for each MCO and the statewide aggregate.[9-11]

Table 9-3—Comparison of 2015 Adult Medicaid CAHPS Results

	Anthem	Coventry	INTotal	Optima	VA Premier	Statewide Aggregate
Global Ratings						
Rating of Health Plan	68.1%	55.1%	55.0%	65.3%	64.2%	61.5%
Rating of All Health Care	60.2%	50.2%	54.7%	52.3%	47.8%	53.0%
Rating of Personal Doctor	68.2%	63.6%	65.6%	65.8%	64.1%	65.4%
Rating of Specialist Seen Most Often	75.5%	57.9%	70.0%	63.6%	67.0%	66.8%
Composite Measures						
Getting Needed Care	82.6%	81.7%	80.6%	84.5%	84.4%	82.8%
Getting Care Quickly	81.8%	86.9%	80.0%	81.2%	84.3%	82.8%
How Well Doctors Communicate	92.5%	92.0%	89.4%	90.8%	89.5%	90.8%
Customer Service	92.5%	86.5%	81.4%	89.6%	87.6%	87.5%
Shared Decision Making	78.7%	80.9%	74.9%	78.9%	80.2%	78.7%

If there were less than 100 respondents for a measure, this is denoted as Not Applicable (NA) in the table above.
Due to changes to the Shared Decision Making composite, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.
Cells highlighted in yellow represent rates that are equal to or greater than the 2014 NCQA national adult Medicaid average.

Comparison of the statewide aggregate and MCOs' 2015 adult Medicaid CAHPS scores to the 2014 NCQA national adult Medicaid averages revealed the following summary results:

- The Statewide Aggregate score was not 5 or more percentage points higher or lower than the NCQA national adult Medicaid average for any of the eight comparable measures.
- Anthem scored 5 or more percentage points higher than the NCQA national adult Medicaid average on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of*

[9-11] Statewide Aggregate scores were derived by calculating a mean of the combined scores of the five MCOs (i.e., average of the MCOs' top-box rates combined).

Specialist Seen Most Often, and *Customer Service*.

- Coventry scored 5 or more percentage points lower than the NCQA National adult Medicaid average on one measure, *Rating of Specialist Seen Most Often*, and 5 or more percentage points higher than the NCQA national adult Medicaid average on one measure, *Getting Care Quickly*.
- INTotal scored 5 or more percentage points lower than the NCQA national adult Medicaid average on one measure, *Customer Service*.
- Optima scored 5 or more percentage points higher than the NCQA national adult Medicaid average on one measure, *Rating of Health Plan*.
- VA Premier scored 5 or more percentage points higher than the NCQA national adult Medicaid average on one measure, *Rating of Health Plan*.

Comparison of the MCOs' 2015 adult Medicaid CAHPS scores revealed the following summary results:

- Anthem scored highest among the five MCOs on six measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Customer Service*. Further, Anthem did not score lowest among the MCOs on any of the measures.
- Coventry scored highest among the five MCOs on two measures: *Getting Care Quickly* and *Shared Decision Making*. However, Coventry also scored lowest among the MCOs on two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*.
- INTotal did not score highest among the five MCOs on any of the measures, and scored lowest among the five MCOs on six measures: *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.
- Optima scored highest among the five MCOs on one measure, *Getting Needed Care*, and did not score lowest among the MCOs on any of the measures.
- VA Premier did not score highest among the five MCOs on any of the measures, and scored lowest among the MCOs on *Rating of All Health Care*.

Child Medicaid CAHPS Results

Table 9-4 presents 2015 child Medicaid CAHPS top-box scores (e.g., the percentage of top-level responses) for each MCO and the statewide aggregate.[9-12]

[9-12] The scores for the Statewide Aggregate were derived by calculating a mean of the combined scores of the five MCOs (i.e., average of the MCOs' top-box rates combined).

Table 9-4—Comparison of 2015 Child Medicaid CAHPS Results						
	Anthem	Coventry	INTotal	Optima	VA Premier	Statewide Aggregate
Global Ratings						
Rating of Health Plan	70.4%	66.7%	79.4%	78.5%	69.6%	72.9%
Rating of All Health Care	65.5%	63.4%	64.2%	75.2%	66.2%	66.9%
Rating of Personal Doctor	78.1%	76.2%	69.3%	78.3%	73.5%	75.1%
Rating of Specialist Seen Most Often	NA	NA	72.6%	NA	NA	72.6%
Composite Measures						
Getting Needed Care	85.1%	88.3%	81.5%	87.8%	84.8%	85.5%
Getting Care Quickly	87.5%	93.9%	87.0%	92.9%	91.9%	90.7%
How Well Doctors Communicate	94.0%	94.4%	89.8%	95.0%	95.3%	93.7%
Customer Service	NA	86.5%	83.8%	87.3%	NA	85.9%
Shared Decision Making	NA	NA	67.3%	78.1%	81.8%	75.8%

If there were less than 100 respondents for a measure, this is denoted as Not Applicable (NA) in the table above.
Due to changes to the Shared Decision Making composite, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.
Cells highlighted in yellow represent rates that are equal to or greater than the 2014 NCQA national child Medicaid average.

Comparison of the statewide aggregate and MCOs' 2015 child Medicaid CAHPS scores to the 2014 NCQA national child Medicaid averages revealed the following summary results:

- The child Medicaid Statewide Aggregate score was not 5 or more percentage points higher or lower than the NCQA national child Medicaid average on any of the measures.
- INTotal scored 5 or more percentage points higher than the NCQA national child Medicaid average on one measure, *Rating of Health Plan*.
- Optima Health Plan scored 5 or more percentage points higher than the NCQA national child Medicaid average on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- Three MCOs (Anthem, Coventry, and VA Premier) did not score 5 or more percentage points higher or lower than the NCQA national child Medicaid average on any of the measures.

Comparison of the MCOs' 2015 child Medicaid CAHPS scores revealed the following summary results:

- Anthem did not score highest or lowest among the five MCOs on any of the measures.
- Coventry scored highest among the five MCOs on two measures: *Getting Needed Care* and *Getting Care Quickly*. However, Coventry also scored lowest among the MCOs on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- INTotal scored highest among the five MCOs on one measure, *Rating of Health Plan*. However, INTotal also scored lowest among the MCOs on six measures: *Rating of Personal Doctor*,

Getting Needed Care, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service,* and *Shared Decision Making*.

- Optima scored highest among the five MCOs on three measures, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service*. Further, Optima did not score lowest among the MCOs on any of its reportable measures.
- VA Premier scored highest among the five MCOs on two measures, *How Well Doctors Communicate* and *Shared Decision Making*. Further, VA Premier did not score lowest among the MCOs on any of its reportable measures.

Conclusions and Recommendations

FAMIS Program

Based on an evaluation of the FAMIS program's 2015 general child CAHPS survey results, HSAG recommends that the FAMIS program focus QI initiatives on enhancing members' experiences with *Getting Care Quickly*. For the population of children with chronic conditions, based on the FAMIS' program 2015 CAHPS survey results, HSAG recommends that the FAMIS program focus QI initiatives on *Rating of Health Plan* and *Customer Service.*

The following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was lower than the NCQA national child Medicaid average by 5 percentage points or more. The FAMIS program should evaluate these general recommendations in the context of its own operational and QI activities.

Rating of Health Plan

- **Alternatives to One-on-One Visits**—The program should engage in efforts that assist providers in examining and improving their systems' capabilities to manage patient demand. As an example, the program could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments. Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.
- **Health Plan Operations**—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.
- **Promote Quality Improvement Initiatives**—Implementation of organization-wide QI initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and

communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Further, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

Getting Care Quickly

- **Decrease No-Show Appointments**—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The program can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the program in determining targeted, potential resolutions.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Open Access Scheduling**—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

Customer Service

- **Call Centers**—An evaluation of current program call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- **Creating an Effective Customer Service Training Program**—The program could consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and

service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

- **Customer Service Performance Measures**—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

Medallion 3.0 CAHPS

Based on an evaluation of the MCOs' 2015 adult and child Medicaid CAHPS survey results, HSAG recommends that the MCOs focus QI initiatives on enhancing members' experiences in those areas where CAHPS measure performance was lower than the 2014 NCQA national Medicaid average by 5 percentage points or more, or lower than the NCQA national Medicaid average. The following is a summary of recommended area(s) for improvement based on these findings.

- An evaluation of Anthem's 2015 adult and child Medicaid CAHPS results revealed that the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that Anthem focus QI initiatives where measure performance was below the NCQA national average. For the child Medicaid population, Anthem scored below the NCQA national average on *Rating of All Health Care* and *Getting Care Quickly*.
- Based on an evaluation of Coventry's 2015 adult Medicaid CAHPS results, HSAG recommends that the MCO focus QI initiatives on enhancing members' satisfaction with *Rating of Specialist Seen Most Often.* For the child Medicaid population, HSAG recommends that Coventry focus QI initiatives on *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*.
- Based on an evaluation of INTotal's 2015 adult Medicaid CAHPS survey results, HSAG recommends that the MCO focus QI initiatives on enhancing members' experiences with *Customer Service*. For the child Medicaid population, HSAG recommends that INTotal focus QI initiatives on *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate,* and *Customer Service*.
- Based on an evaluation of Optima's 2015 adult Medicaid CAHPS survey results, HSAG recommends that the MCO focus QI initiatives on enhancing members' experiences with *Rating of Specialist Seen Most Often*. For the child Medicaid population, HSAG recommends that Optima focus QI initiatives on *Customer Service*.
- Based on an evaluation of VA Premier's 2015 adult Medicaid CAHPS survey results, HSAG recommends that the MCO focus QI initiatives on enhancing members' satisfaction with *Rating of All Health Care* and *How Well Doctors Communicate*. For the child Medicaid population, HSAG recommends that VA Premier focus QI initiatives on *Rating of All Health Care*, *Rating of Personal Doctor*, and *Getting Needed Care*.

The following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was

lower than the NCQA national Medicaid average. Each MCO should evaluate these general recommendations in the context of their own operational and QI activities.

Rating of Health Plan

- **Alternatives to One-on-One Visits**—The MCO should engage in efforts that assist providers in examining and improving their systems' capabilities to manage patient demand. As an example, the MCO could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments. Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.
- **Health Plan Operations**—It is important for MCOs to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.
- **Promote Quality Improvement Initiatives**—Implementation of organization-wide QI initiatives is most successful when MCO staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Further, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

Rating of All Health Care

- **Access to Care**—The MCO should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The MCO should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols for access to care issues can assist in this process by ensuring issues are handled consistently across all practices. As an example, the MCO could develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.
- **Patient and Family Engagement Advisory Councils**—Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. As such, the MCO should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource for feedback on health care processes. Involvement in advisory councils can provide a structure and process for

ongoing dialogue and creative problem-solving between the MCO and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; design of materials or tools that support the provider-patient relationship; and marketing of health care services.

Rating of Personal Doctor

- **Maintain Truth in Scheduling**—The MCO can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. The MCO could provide assistance or instructions to those physicians unfamiliar with this type of assessment. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.
- **Direct Patient Feedback**—The MCO can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. The MCO can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Asking patients to describe what they liked most, what they liked least, and one thing they would like to see changed about the care they received during their recent office visit can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest.
- **Physician-Patient Communication**—The MCO should encourage physician-patient communication to improve patient satisfaction and outcomes. The health plan can create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication techniques, and effectively communicating expectations and goals of health care treatment.
- **Improving Shared Decision Making**—The MCO should encourage skills training in shared decision making for all physicians. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs.

Rating of Specialist Seen Most Often

- **Planned Visit Management**—The MCO could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt

general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

- **Skills Training for Specialists**—The MCO could create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
- **Telemedicine**—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Further, the local provider is more involved in the consultation process and more informed about care the patient is receiving.

Getting Needed Care

- **Appropriate Health Care Providers**—The MCO should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner.
- **Interactive Workshops**—The MCO should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.
- **"Max-Packing"**—The MCO can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.
- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a web-based system, can improve the communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral, and allows providers access to a standardized referral form to ensure all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

Getting Care Quickly

- **Decrease No-Show Appointments**—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The MCO can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the MCO in determining targeted, potential resolutions.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Open Access Scheduling**—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

How Well Doctors Communicate

- **Communication Tools for Patients**—The MCO can encourage patients to take a more active role in the management of their health care by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Further, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options. MCO could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care.
- **Health Literacy**—Often, health information is presented to patients in a way that is too complex and technical, which can result in patients' reluctance to adhere to suggested care and poor health outcomes. To address this issue, the MCO should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication. Additionally,

health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.

- **Language Barriers**—The MCO could consider hiring interpreters that serve as full-time staff members at provider offices with a high volume of non-English-speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a clearer understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on-site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.

Customer Service

- **Call Centers**—An evaluation of current MCO call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- **Creating an Effective Customer Service Training Program**—The MCO could consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.
- **Customer Service Performance Measures**—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

10. Best and Emerging Practices for Improving Quality of Care and Services

This section of the report includes the best and emerging practices shared by the MCOs. These effective and promising practices were developed to meet the needs of members, improve HEDIS scores, increase member and provider satisfaction, and close member care gaps.

Anthem

Anthem's Clinic Day Program initiative is a partnership with network providers in hosting a series of Clinic Day events to treat Anthem members who have not completed specific recommended health services. A key benefit of having Clinic Days is to encourage open communication between the member, provider, and Anthem. The goals of offering Clinic Days are to engage members and providers while improving access to care and patient compliance.

Clinic Days are considered valuable because they encourage members to receive the health services they need; bolster member and provider satisfaction; can increase HEDIS scores; and ultimately improve the quality of life for members, specifically in relation to certain health care needs.

A Clinic Day event occurs when a provider agrees to hold open appointments for particular health services for Anthem members over the course of one or more days. Anthem sends invitations to a subset of members who have not completed specific recommended health services to participate in the Clinic Day. Every effort is made to help prevent "no-shows" to ensure the day is successful. Prior to the event, Quality Management's health outreach specialists work with members to identify solutions to any barriers that may lead to a no-show. Transportation arrangements are made for qualifying Anthem members. In addition, a gift card incentive is provided to members for their participation.

During the Clinic Day event, Anthem community relations representatives and health outreach specialists conduct educational activities with members to:

- Answer any questions about member benefits.
- Help members obtain resources (Social Security office addresses, phone numbers, etc.).
- Provide members with Anthem contact information for any issues that arise.
- Offer health education materials and giveaways.

Coventry

Throughout 2015, Coventry focused on improving members' experience with the health plan. New technology-based solutions were introduced to allow Coventry members to take control of their health care decisions. A multipronged outreach approach was utilized to ensure members were educated and reminded about wellness activities. Advanced customer service training was conducted and enhanced programs were implemented. Together, all of these initiatives are aimed at improving the quality of care for each member at the point in which they are interacting with the health plan.

Coventry's online wellness portal, My Online Services, provides a wealth of information for Coventry members. In addition to an assortment of educational materials, a personal health record is available that is populated with eligibility, claims, and provider data to assist members in organizing and tracking their health care goals. Self-management tools for tracking wellness and condition-related statistics and a health risk appraisal are two instruments specifically designed to assist members to make the best decisions about their care. Optional digital wellness programs can be customized, based on the appraisal responses and selected opportunities to improve health, such as coaching for smoking cessation. Coventry encourages members to utilize My Online Services via newsletter articles and website reminders.

The customer service department is often the member's initial point of contact with the health plan. Since this interaction is so important to members, Coventry recently launched a new catch phrase at the end of each member call: "Thank YOU for being the best part of CoventryCares." This slogan was designed to remind members that they are the most important part of the health plan. Customer service representatives also attended soft skills training focused on improving the member experience with each call. The goal is to achieve first-call resolution and improve the quality of the services available to Coventry members via highly trained, qualified, and caring staff.

Coventry utilizes member satisfaction survey data, informal member feedback, and national customer service standards to develop best practices that continue to improve the member experience with the health plan.

INTotal

In 2015, INTotal Health implemented a number of quality practices to improve the health and well-being of members and to strengthen the collaboration with providers and community partners. Below are several initiatives that INTotal began in 2015 and will continue to expand and grow in 2016.

HEDIS

In 2015, INTotal Health introduced a HEDIS Calendar initiative aimed at improving HEDIS scores through staff engagement and provider and member outreach focused on key HEDIS measures. The Quality team along with executive leadership formed a committee designed to oversee the calendar initiatives and activities. A measure was assigned for each month that corresponded with a nationally recognized health initiative (e.g., January was national eye month; therefore, the measure was CDC Eye Exams). Multidepartment teams volunteered to work on a measure in which they had a particular interest. Each team set goals, developed a plan, and conducted data analysis on the impact of their project. Initiatives included working with radiology offices to secure appointments for INTotal members to have mammograms, connecting with optometrist offices to help schedule office and in-home eye exams for diabetic members, and partnering with INTotal's Provider Relations, Case Management, and Outreach departments to promote prenatal and postpartum care by visiting provider offices, calling and sending mailings to members, and encouraging members to participate in INTotal's robust prenatal care program.

Appeals and Grievances

As a strategy to improve communication and collaboration with members, the member advocate, while addressing a grievance, will also identify and discuss HEDIS gaps in care with the member if it is appropriate. The member advocate will provide information about the gap in care as a part of a decision letter or may discuss the measure and gap during a phone conversation. The feedback from members has been overwhelmingly positive as they appreciate that the member advocate takes the time to understand and support their individual health care needs.

Behavioral Health Home

INTotal Health Case Managers contact hospital discharge planners of members who are hospitalized for psychiatric reasons immediately following notification of the hospitalization. This helps to coordinate follow-up care for the member and meet the 30-day follow-up appointment measure. Additionally, members who meet the state requirements for the Behavioral Health Home (BHH) pilot are followed by a case manager and enrolled, at a minimum, in care coordination. Case managers involved with members enrolled in the BHH pilot establish relationships with the member's providers to coordinate care between primary care physicians and behavioral health providers. A goal for 2016 is to increase the number of visits by INTotal health case managers to members while hospitalized for psychiatric reasons to establish relationships with the member and to become more involved in care coordination.

Kaiser Permanente

Health Education

Regional health education provides in-person and online, evidence-based programs and tools that are designed to help members start and maintain healthy living behaviors. The most well-attended programs are *InSTEP with Diabetes* and the *Prenatal Care Series* (prenatal, newborn care, and breastfeeding support). Examples of additional program offerings include:

- Nutrition and weight management classes.
- Online health assessment programs.
- Classes for ongoing conditions such as chronic kidney disease and back pain.
- Online video programs and interactive tools for topics such as asthma and pre-surgical education.

Comprehensive Perinatal Program

Kaiser Permanente Mid-Atlantic States' **Comprehensive Perinatal Program** has three interrelated components. The program's goal is to optimize a pregnant woman's chance of delivering a healthy baby.

- **Early Start** is a confidential, evidence-based program that connects the perinatal addictions specialist to pregnant women who are using alcohol, tobacco, or drugs.
- **High-risk perinatal case managers** offer assistance with WIC enrollment, transportation to medical appointments, housing, employment, and safety planning for women in an unhealthy relationship.
- **Regional perinatal service center** nurses identify members at risk for diabetes, hypertension, or preterm delivery and provide education, care coordination, and close monitoring through frequent phone contact.

Flu Vaccination Program

Program Philosophy

Kaiser Permanente's 2015–2016 Flu Vaccination Program is focused on ensuring that all members of Kaiser Permanente, including Medicaid and the State Children's Health Insurance Program, have the ability to receive a vaccination, at no additional cost, as part of the Kaiser Permanente preventive model. Patients are strongly encouraged to come to any of the Kaiser Permanente medical office buildings to receive a flu shot. No appointment is necessary and many of the centers are open 24 hours.

Access to Immunization

From September through December, flu clinics were opened and highly visible in every medical office building to aid in the access and ease for members. Kaiser Permanente implemented a large advertising campaign this year to assist in communicating this value-added benefit to members. Continuing flu season 2015 into 2016, providers will continue to see member walk-ins for a flu shot at all Kaiser Permanente locations.

Program Outreach and Results

Along with open access, healthcare teams have the ability to track immunizations, allowing providers to know real time if a patient has been immunized. This is part of the proactive care model, ensuring staff are asking every patient at every encounter to get a flu shot. Additionally, staff routinely use secure email to reach out to patients who have not been immunized.

The current Medicaid percentage for Virginia is approximately 37 percent, or 3,570 Medicaid members who are currently vaccinated as of January 10, 2016.

Pediatric Care Delivery

Health Assessments and Prevention Screening

Kaiser Permanente offers an integrated approach to members. Kaiser Permanente is dedicated to prevention and screening for the youngest members.

Kaiser Permanente staff utilizes health questionnaires at every health assessment as a screening tool for development, nutrition, and anticipatory guidance. In addition all members are screened for developmental delay with Ages and Stages questionnaires at ages 9, 18, 24, and 30 months.

Members are also screened for autism at 18 and 24 months using the Modified Checklist for Autism in Toddlers (MCHAT). This approach allows for early identification and intervention for any fine and gross motor developmental delays, speech delays, or autistic behaviors.

Program Outreach

Kaiser Permanente proactively contacts members for preventive care. One of the major initiatives is outreach for routine health assessments and immunizations. Kaiser Permanente's integrated health care system captures and monitors when members are due for a physical or immunization.

Kaiser Permanente also participates with the Virginia Immunization System to ensure accurate information is obtained for members.

Kaiser Permanente partnered with the Bright Smiles program to ensure that all of the providers and health plan staff were trained on the Fluoride Training program.

Optima

Optima Family Care continued **use of mobile phones (TracPhone) and digital health messaging programs (Voxiva)** Members have access to Voxiva's suite of digital health programs for maternal and child health (Text4baby and Text4kids), as well as adult health and wellness (Txt4health). To date, more than 28,000 members are receiving digital health messages (1,141 Text4baby, 16,188 Text4kids, and 10,701 Txt4health). These text message-based programs are designed to educate and support members; encourage them to follow recommended guidelines for preventive care, vaccinations and screenings; and inform them of health plan services and benefits. Voxiva has developed these programs to help health plans improve key quality measures (HEDIS and EPSDT [Early and Periodic Screening, Diagnosis, and Treatment]) and increase member retention. Independent evaluations of the services demonstrate improved outcomes on key quality measures such as appointment attendance and timely immunizations.

Emergency Room (ER) outreach targets members who may be overutilizing the ER/Emergency Department (ED). A member who has visited the ER three to six times within a six-month period and has had no primary care physician (PCP) visits will receive an outreach call by a member outreach representative or a home visit by a community outreach coordinator. That contact includes intervention through education and a medical health risk assessment to determine if other resources are needed, such as behavioral health and case management. Optima staff educates members on Access to Care standards and clarifies the reason for the ER visit. Optima staff confirms that a follow-up appointment to a member's assigned PCP was kept or was at least scheduled. If not, staff confirm the PCP on file is correct and collaborate with the member to establish a relationship with that physician.

Health and Acute Care Program (HAP) members: Engagement and assessment of HAP members at three times the rate of non-HAP members.

Prenatal: The Optima Health Partners in Pregnancy program is a support program for expectant mothers. In addition to working directly with expectant mothers, conference calls are held monthly to monitor progress of referred mother/baby cases with 10 community partner sites (Norfolk, Chesapeake, Portsmouth, Richmond, Charlottesville, Petersburg, Hampton, Newport News, Suffolk, and Virginia Beach).

Controlling Blood Pressure: Case management follows members with a diagnosis of high blood pressure to verify compliance with medications and follow-up visits to their physician. Optima Family Care added tips to the Member Service telephone line regarding cardiac/heart disease. Information was added to the Member Outreach calendar that is sent to all households in December of each year.

Developed QI packets specifically targeted to pediatricians and other PCPs, as well as behavioral health and OB/GYN providers, addressing HEDIS measures and their corresponding Screening , Test, or Care Needed definitions. Noncompliant members are identified and letters are sent to the corresponding physicians.

VA Premier

Foster Care Program

Since the implementation of the Children with Special Health Care Needs corrective action plan, accepted by DMAS on March 3, 2015, and through extensive, ongoing process monitoring and improvements, the foster care assessment process has undergone continual fine-tuning to remove identified system variations and to provide uniformity in the completion of Medallion 3.0 health risk assessments (HRAs) for foster care members. This process illustrates VA Premier's best and emerging practices for improving the quality of care and services for the foster care members.

Prior to July 1, 2015, some challenges identified by VA Premier in regard to the Foster Care assessment process included the then current health assessment tool (Intake Screening Tool), having multiple patient care coordinators (PCCs) reaching out to the foster care families and the DSS agencies, and also with having multiple PCCs completing and entering the foster care health assessments.

In March 2015, VA Premier implemented a new VA Premier Health assessment tool named the Medallion 3.0 HRA. The Medallion 3.0 HRA was a major improvement over the previous tool used by VA Premier titled "Intake Screening Tool." The Medallion 3.0 HRA is a more comprehensive health assessment tool and allows for the member to be more uniformly stratified into the correct level of case management based on the assessment responses. Also during this time, VA Premier began mailing the foster care members a "welcome" letter along with a paper copy of the Medallion 3.0 HRA and a return stamped envelope. This mailing allows members to respond quickly and at their convenience to VA Premier's initial member outreach attempt. If there is no response to the mailing, a patient care coordinator would attempt to reach the member through two call attempts. Then, if no successful contact is made, a representative from the Medical Outreach team would make a home visit to the member. An ongoing challenge to contacting the foster care members is having up-to-date demographic information, especially telephone numbers. The addition of medical outreach to the

foster care assessment process has been instrumental in successfully locating the foster care members and completing the Medallion 3.0 HRA within 60 days of enrollment.

Beginning on July 1, 2015, VA Premier appointed a dedicated senior patient care coordinator (PCC) to perform all foster care member outreach attempts and to complete all Medallion 3.0 HRAs within the VITAL Case Management System. Having a single point of entry for the foster care assessment process has greatly improved process consistency and quality while avoiding process variations. This senior PCC has been extensively trained to only enter fully completed Medallion 3.0 HRA and is considered a subject matter expert on the foster care assessment process. Also, having one dedicated point of contact for the foster care assessment process has proven beneficial when working with the Department of Social Services agencies across Virginia. It has been challenging to successfully contact each foster care case worker within each DSS agency when attempting to complete the Medallion 3.0 HRA for the foster care members. The senior PCC is developing working relationships with each DSS, and these relationships are crucial to the successful assessment of the foster care members. In addition to the previously mentioned process enhancements, to assure the quality component of the Medallion 3.0 HRA, a monthly departmental audit is conducted by the manager of case management. A random sample of five completed Foster Care Medallion 3.0 health risk assessments is audited to verify that the foster care assessment process is being accurately followed and all Medallion 3.0 HRAs are answered completely.

Beginning in December 2015, a report of foster care members that VA Premier was unable to contact is submitted to DMAS during the third week of each month. The report includes the member's name, Medicaid number, date of birth, and address/phone number. A comments section details the contact attempts made to the member's guardian and also includes all contact attempts to the Department of Social Services. A second report, with the same format and also submitted the third week of each month, is sent to DMAS identifying members that are 18 years old and have left the foster care program according to the Department of Social Services. These members require a status update by the Department of Social Services to remove them from the foster care program.

11. Assessment of MCO Follow-Up on Prior Year Recommendations

In the past, MCOs were not required to report on follow-up on prior year EQR Technical Report recommendations. Beginning with this 2015 EQR Technical Report, MCOs are required to track applicable recommendations and report on follow-up prior to the compilation of the 2016 EQR Technical Report.

Appendix A. Performance Measure Validation Methodology

Overview

The Virginia Department of Medical Assistance Services (DMAS) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Virginia. The State refers to its CHIP program as Family Access to Medical Insurance Security (FAMIS). DMAS contracts with six privately owned managed care organizations (MCOs) to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. The six MCOs are: Anthem HealthKeepers Plus, CoventryCares of Virginia, INTotal Health, Optima Family Care, Virginia Premier Health Plan, and Kaiser Permanente.

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with MCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the BBA described at Code of Federal Regulations (CFR) at 42 CFR §438.358(b)(2). The purpose of performance measure validation (PMV) is to assess the accuracy of performance measure rates reported by MCOs and to determine the extent to which performance measures calculated by the MCOs follow state specifications and reporting requirements. According to the EQR protocol[A-1] developed by CMS, the mandatory PMV activity can be performed by the State Medicaid agency, an agent that is not an MCO, or external quality review organization (EQRO).

To meet the PMV requirements, DMAS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct the performance measure validation (PMV) for each MCO, validating the data collection and reporting processes used to calculate the performance measure rates. HSAG has contracted with Aqurate Health Data Management Inc. (Aqurate) to assist in conducting the validation of performance measures.

Annually, DMAS identifies a set of performance measures that the MCOs are required to calculate and report. Two measures were selected from the HEDIS developed by the National Committee for Quality Assurance (NCQA), and two measures were developed by DMAS. The measurement period identified by DMAS is CY 2014 for HEDIS measures and SFY 2015 (July 1, 2014–June 30, 2015) for non-HEDIS measures. Appendix A lists the selected performance measures, the method required for data collection, and the specifications that the MCOs were required to use.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

Objectives

The primary objectives of HSAG's PMV process are to:

- Evaluate the accuracy of the performance measure data reported by the MCOs.
- Determine the extent to which the performance measures calculated by the MCOs or DMAS (or on behalf of the MCOs or DMAS) follow DMAS' reporting requirements.

Description of Validation Activities

HSAG will focus on data used for calculating and reporting the performance measures for CY 2015 (January 1, 2014, through December 31, 2014) for the HEDIS measures and SFY 2015 (July 1, 2014–June 30, 2015) for non-HEDIS measures. HSAG will use several validation strategies to achieve the validation objectives.

Pre-on-site Activities

HSAG will conduct the validation activities as outlined in the CMS PMV protocol. HSAG will prepare a document request letter for the MCOs outlining the steps in the PMV process. The document request letter will include a request for source code for each performance measure; a completed HEDIS 2015 Record of Administration, Data Management, and Processes (Roadmap); a completed Information Systems Capabilities Assessment Tool (ISCAT); any additional supporting documentation necessary to complete the audit; a timetable for completion; and instructions for submission. The document request letter will also provide guidance to the MCOs that when there are questions in the ISCAT that are covered in the Roadmap submission, MCOs may reference the Roadmap by providing the details about the section or document title and page number from the Roadmap in lieu of a response. In addition, HSAG will forward a letter that includes requested documentation needed to complete the medical record review validation (MRRV) process. HSAG will provide an introductory overview of the performance validation process to the MCOs before the document request packet is sent. Approximately two weeks prior to the on-site visit, HSAG will provide the MCOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG will also conduct a pre-on-site conference call with the MCOs to discuss on-site logistics and expectations, important deadlines, and any outstanding questions.

Based on the scope of the validation, HSAG will assemble a validation team based on the full complement of skills required for validating the specific performance measures and conducting the PMV for each MCO. The team will be composed of a lead auditor and several team members.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data HSAG will review and how HSAG conducted an analysis of these data:

- **NCQA's HEDIS 2015 Roadmap**: The MCOs will complete and submit the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures. HSAG will use responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT)**: The MCOs will complete and submit an ISCAT for HSAG's review of the required DMAS-developed measures. HSAG will use responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation:** The MCOs will be responsible for completing the medical record review section within the Roadmap. In addition, HSAG will request that the MCOs submit the following documentation for review: medical record hybrid tools and instructions, training materials for medical record review staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG will conduct over-read of 30 records from the hybrid sample. HSAG will follow NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and will then use the MRRV results to determine if the findings impact the audit results for any performance measure rate.
- **Source code (programming language) for performance measures:** MCOs that calculate the performance measures using source code will be required to submit source code for each performance measure being validated. HSAG will complete line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG will identify any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCOs that do not use source code will be required to submit documentation describing the steps taken for performance measure calculation.
- **Supporting documentation:** HSAG will request documentation that provides additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG will review all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-site Activities

During the on-site visit, HSAG will collect additional information to compile PMV findings, using several methods, including interviews, system demonstration, review of data output files, observation of data processing, and review of data reports. The on-site strategies will include:

- **Opening meetings**—Include introductions of the validation team and key MCO staff involved in the calculation or reporting of the performance measures. The purpose of the PMV, the required documentation, basic meeting logistics, and queries to be performed will be discussed.
- **Review of ISCAT and Roadmap documentation**—This session is designed to be interactive with key MCO staff so that the validation team can obtain a complete picture of all the steps taken to generate responses to the ISCAT and Roadmap, and evaluate the degree of compliance with written documentation. HSAG will conduct interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice.

- **Evaluation of data systems and processes**—This session will include a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which will evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

  HSAG will conduct interviews with appropriate staff members familiar with the processing, monitoring, and calculation of the performance measures. HSAG will use these interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.

  HSAG will perform additional validation using primary source verification (PSV) to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG will assess the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG will select cases across measures to verify that the MCOs have system documentation that support that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors are detected, the outcome is determined based on the type of error. For example, the review of one case may be sufficient in detecting a programming language error and as a result, no additional cases related to that issue may be reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference**—At the end of each on-site visit, HSAG will summarize its preliminary findings and revisit the documentation requirements for any post-on-site activities.

Post-On-site Activities

After the on-site visit, HSAG will review any final performance measure rates submitted by the MCOs to DMAS and follow up with each MCO on any outstanding issues identified during the documentation review and/or during the on-site visits. Any issues identified from the rate review will be communicated to the MCO as a corrective action as soon as possible so that the rates can be revised before the PMV report is issued.

HSAG will prepare a PMV report for each MCO, documenting the validation findings. Based on all validation activities, HSAG will determine the validation result for each performance measure listed in Table A-2 below. The CMS PMV protocol identifies possible validation results for performance measures, which are defined in the table below.

Table A-1—Validation Results and Definitions for Performance Measures

Report (R)	Measure was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which: (1) the MCO rate was materially biased or (2) the MCO was not required to report.

According to the CMS protocol, the validation result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Not Reported" (NR). It is possible for a single audit element to receive a validation result of NR when the impact of the error associated with that element biased the reported performance measure rate by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "Report" (R).

Any corrective action that cannot be implemented in time will be noted in the MCOs' PMV report under recommendations. If the corrective action is closely related to accurate rate reporting, HSAG may render a particular measure as NR.

Performance Measure List for SFY 2014–2015

The following table lists the performance measures selected by DMAS, the method (i.e., hybrid or admin) required for data collection, and the specifications the MCOs are required to use.

Table A-2—2015 Performance Measures Selected by DMAS for Validation

Performance Measure	Specifications	Methodology
Foster Care Assessments	DMAS	Hybrid*
MCO Claims Processing	DMAS	Admin
Adolescent Well-Care Visits (AWC)	HEDIS	Hybrid
Follow-Up After Hospitalization for Mental Illness (FUH) 7- and 30-day	HEDIS	Admin

* Hybrid refers to a review of both the administrative data system as well as foster care assessments contained in the MCOs' care/case management systems.

Appendix B. NCQA Quality Compass 50th Percentile Values

NCQA Quality Compass 50th Percentile Values

For reference, included in Table B-1 are the 2012, 2013, and 2014 NCQA Quality Compass 50th percentile values for the HEDIS measures that were evaluated for the MCOs.

Table B-1—NCQA Quality Compass 50th Percentile Values

	2012 NCQA Quality Compass 50th Percentile	2013 NCQA Quality Compass 50th Percentile	2014 NCQA Quality Compass 50th Percentile
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	49.65	48.18	48.51
Childhood Immunization Status			
Combination 2	75.35	76.89	75.18
Combination 3	71.93	72.88	72.33
Lead Screening in Children			
Lead Screening in Children	71.41	72.26	70.86
Well-Child Visits in the First 15 Months of Life			
No Well-Child Visits[1]	1.22	1.22	1.46
Six or More Well-Child Visits	62.95	65.16	62.86
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.26	72.26	71.76
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	50.46	51.32	57.37^
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	86.13	85.88	84.30
Postpartum Care	64.98	63.99	62.84
Care for Chronic Conditions			
Cholesterol Management for Patients With Cardiovascular Conditions			
LDL-C Control (<100 mg/dL)	42.39	41.82	—
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	82.38	83.16	83.88
HbA1c Control (<8.0%)	48.72	48.57	46.43
Eye Exam (Retinal) Performed	52.88	54.31	54.14
LDL-C Screening	76.16	76.28	—
LDL-C Control (<100 mg/dL)	35.86	34.89	—
Blood Pressure Control (<140/90 mm Hg)	63.50	61.03	61.31

Table B-1—NCQA Quality Compass 50th Percentile Values			
	2012 NCQA Quality Compass 50th Percentile	2013 NCQA Quality Compass 50th Percentile	2014 NCQA Quality Compass 50th Percentile
Controlling High Blood Pressure			
Controlling High Blood Pressure	57.52	56.20	56.46
Use of Appropriate Medications for People with Asthma			
5–11 Years	91.59	90.31	91.11
12–18 Years	86.96	85.88	87.31
19–50 Years	75.53	74.76	75.83
51–64 Years	73.81	72.50	71.63
Total	85.87	84.70	84.96
Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	49.42	51.47	49.66
Effective Continuation Phase Treatment	32.42	35.26	33.93
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	46.06	44.66	42.30
30-Day Follow-Up	67.65	65.85	64.63

[1] *A lower rate indicates better performance for this measure.*

^ *HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. Caution should be exercised when comparing 2014 (or later) NCQA Quality Compass 50th percentiles to prior years.*

— *indicates the measure was retired and was not included in HEDIS 2015 reporting; therefore, the HEDIS 2015 rate and corresponding NCQA Quality Compass 50th percentile value are not presented.*

Appendix C. SFY 2015 Prenatal Care and Birth Outcomes Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a focused study that will provide quantitative information about prenatal care and associated birth outcomes among Medicaid recipients. The Contract Year 2015–2016 Task F.1 Birth Outcomes Focused Study will address the following questions:

- *To what extent do women with births paid by Medicaid receive early and adequate prenatal care?*
- *What clinical outcomes are associated with Medicaid-paid births?*

Study Design

Measurement Period

The study will include all singleton births paid by Virginia Medicaid during CY 2014. Results for CY 2012 and CY 2013 will be taken from previously published reports and included in the current study for trending purposes.

Eligible Population

The eligible population will consist of all live births paid by Virginia Medicaid during the measurement period, regardless of whether the births occurred in Virginia. The birth registry contains records of live births; other pregnancy outcomes will not be included in this study. To examine outcomes among all Medicaid-paid births in light of expected services, births will be grouped into a study population and a comparison group based on the timing and length of Medicaid enrollment. Specifically, the study population will include women continuously enrolled in the FAMIS MOMS, the Medicaid for Pregnant Women, or an "Other Medicaid" program for a minimum of 43 days prior to, and including, the date of delivery. The "Other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women categories. The comparison group will include women enrolled in one of the three Medicaid program groups defined above on the date of delivery, but without prior continuous enrollment. HSAG will conduct tests for statistical significance between CY 2014 results for the study and comparison populations, as directed by DMAS.

Data Collection

Using Medicaid recipient, claims, and encounter data files supplied by DMAS, HSAG will identify members eligible for the study. HSAG will assemble a list of eligible members and submit it to Virginia Department of Health (VDH). VDH will use probabilistic data linking to match HSAG's list of members eligible for the study to birth registry records. In addition to the probabilistic data linkage, VDH will match HSAG's list of study-eligible members to birth registry records using social security numbers. This deterministic data linkage aligns with prior years' study methodology and will be used by HSAG to validate the data linkage. VDH will return a data file to HSAG containing the information from HSAG's original list and all birth registry data fields for matching members for each of the data linkage processes. HSAG will identify study-eligible members as all probabilistically linked or deterministically linked birth registry records. A three-month data run-out period will be allowed between the end of the measurement period and data extraction; data extraction will begin no earlier than April 1, 2015.

Indicators

Study indicators are limited to singleton births, defined using the Plurality field in the birth registry. Since multiple gestation births are subject to different clinical guidelines, results for multiple births will be limited to demographic summaries (e.g., maternal age, Medicaid program, neonatal characteristics) and used for informational purposes only. Table C-1 illustrates the study indicators included in the study as well as the numerator and denominator definitions. Please note that calculation of the measures is contingent on the availability of timely, complete, and accurate data.

Table C-1—Study Indicators

Indicator	Denominator	Numerator
1. Percentage of births with early and adequate prenatal care.	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births with an Adequacy of Prenatal Care Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent. Note: Secondary analyses will be completed to determine the number of singleton, live births with a Kotelchuck Index score greater than or equal to 110 percent (i.e., "Adequate Plus"). This information will be used for informational purposes only.
2. Percentage of births by gestational estimate.[1]	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: 1. Preterm: Less than 37 weeks a. Extremely preterm: <28 weeks b. Very preterm: 28 through 31 weeks c. Moderate preterm: 32 through 33 weeks d. Late preterm: 34 through 36 weeks 2. Term: 37 weeks through 41 weeks (may be reported weekly) a. Early Term: 37 weeks though 38 weeks b. Full Term: 39 weeks through 40 weeks c. Late Term: 41 weeks 3. Post Term: 42 weeks and beyond

Table C-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
3. Percentage of newborns with low birth weight.	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: 1. Overall low birth weight: less than 2,500 grams a. Moderately low birth weight: 1,500 grams through 2,499 grams b. Very low birth weight: less than 1,500 grams
4. Percentage of newborns receiving at least two visits with a primary care provider (PCP) in the 30 days following birth.[2] Note: Supplemental analyses will identify the percentage of newborns receiving (1) zero visits in the 30 days following birth, and (2) one visit in the 30 days following birth.	Number of singleton, live births paid by Virginia Medicaid during the measurement period. Note: Based on the availability and reliability of a birth registry indicator for a newborn's neonatal intensive care unit (NICU) stay, these births may be excluded from the measure.	Number of singleton, live births where the newborn received at least two office visits in the 30 days following birth with any PCP-type provider.[3] Visits must occur on separate days and do not have to be with the same provider. **PCPs** = Pediatricians, family practice physicians, general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. **Office Visits** = Identified from claims/encounter data with any of the following procedure and/or diagnosis codes for office or other outpatient services, home services, preventive medicine, or general medical examination: CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429 HCPCS: G0438, G0439 ICD-9-CM: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Table C-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
5. Percentage of newborns who had at least one emergency department (ED) visit in the 30 days following birth. Note: Supplemental analyses will identify the range in the number of ED visits reported within the 30-day period. Pending review of the data, supplemental analysis may be included to report on the reasons for ED visits.	Number of singleton, live births paid by Virginia Medicaid during the measurement period. Note: Based on the availability and reliability of a birth registry indicator for a newborn's NICU stay, these births may be excluded from the measure.	Number of singleton, live births where the newborn had at least one ED visit in the 30-day period following birth.[4] ED visits will be considered unique by facility, date of service, and member. **ED Visit** = Identified from claims/encounter data with any of the following procedure or revenue codes for emergency department visits: CPT: 99281-99285 CPT: 10040-69979 AND Place of Service = "23" (Emergency Room – Hospital) Revenue: 045x, 0981

[1] Estimated gestational age will be based on the *Clinical Estimate of Gestation* (CEG) provided on the birth certificate. If this estimate is not available, HSAG will attempt to calculate gestation using the date of the *Last Menstrual Period* (LMP) indicated on the birth certificate. Birth certification records missing both CEG and LMP values will be captured in a "missing gestational age" category, or they will be dropped based on the number of identified cases.

[2] An alternate approach to identification of visits with PCP-type providers may be proposed by HSAG after assessing potential limitations to provider type identification in Medicaid data.

[3] Based on the *Virginia EPSDT Periodicity Chart* published online by Virginia DMAS at http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf [Accessed on April 1, 2015], infants are expected to have at least two visits with a PCP-type provider in the first 30 days of life.

[4] ED visits associated with the infant's birth and resulting hospital stay will be excluded, as will ED visits associated with transfers between acute inpatient facilities.

Additionally, unless otherwise specified, all measure results will be stratified by the key demographic categories listed in Table C-2.

Table C-2—Demographic Categories

Demographic Category	Category Values
Medicaid Program	FAMIS MOMS (Eligibility category TBD) Medicaid for Pregnant Women (Eligibility category TBD) An "other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or Medicaid for Pregnant Women program categories.
Medicaid Delivery System	Fee-for-Service (FFS) Managed Care
Maternal Region of Residence Note: Maternal region of residence will be defined based on members' county of residence using the Virginia Managed Care Regions Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).	Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater
Race/Ethnicity Note: Race/ethnicity will be defined based on members' non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the HISPANIC category.	White African American Asian Hispanic Other
Maternal Age[1]	15 years and younger 16 years through 17 years 18 years through 20 years 21 years through 24 years 25 years through 29 years 30 years through 34 years 35 years through 39 years 40 years through 44 years 45 years and older
Maternal Immigration Status	U.S. Citizen (Citizenship Status = "C", "N") Documented immigrant (Citizenship Status = "E", "I", "P", "R") Undocumented immigrant (Citizenship Status = "A") Other (Citizenship Status = "V")

[1] Maternal age categories will be aggregated into four groups for graphic presentation: 18 years and younger, 18 years through 21 years, 22 years through 34 years, and 35 years and older.

Deliverable

HSAG will present the findings of this focused study in a data report. The data report will primarily consist of tables and graphs, with some text discussing the results presented in the tables and graphs. A corresponding PowerPoint slide deck will be produced based on the report. HSAG will also provide a copy of the analysis dataset in a format to be determined by DMAS (e.g., SAS dataset, pipe-delimited text file).

Appendix D. SFY 2015 Foster Care Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a focused study that will provide quantitative and qualitative information about foster care children receiving medical services through Medicaid managed care plans (MCPs). The Contract Year 2 Task F.2 Foster Care Focused Study will address the following question: *To what extent did children in foster care receive the expected preventive and therapeutic medical care in the first year of managed care service delivery?*

Study Design

Measurement Period

The study will examine services received by foster care children from July 1, 2014, though June 30, 2015 (i.e., the first full year of statewide managed care service delivery for these members).

Eligible Population

The eligible population will consist of all Medicaid children under 18 years of age as of July 1, 2014, identified by DMAS as enrolled in Medicaid under the aid category for children in foster care (Aid Category "76").

Since this population was newly enrolled into managed care service delivery, HSAG will identify all children enrolled in the foster care aid category at any point during the measurement period. HSAG will provide information on trends in managed care enrollment among all children in foster care. However, quality and utilization measures within this study will be limited to children enrolled in managed care with any MCP or combination of MCPs from July 1, 2014, through June 30, 2015, with one or more gaps in enrollment totaling no more than 45 days.

Data Collection

Administrative Data

As select study indicators will benefit from supplemental data, immunization registry data may be extracted by the Virginia Department of Health (VDH) and submitted to HSAG. Once received, HSAG will use probabilistic data linkage methods to associate the immunization data with Medicaid members eligible for this study. To conduct the probabilistic matching and subsequent analyses, HSAG will extract the member information needed for the study from the data already received from DMAS. In addition, DMAS will supply HSAG with dental encounter data from the Medicaid Dental Benefit Manager (DBM), DentaQuest, and behavioral health encounter data from Magellan. A three-

month data run-out period will be allowed between the end of the measurement period and data extraction; data extraction will begin no earlier than October 1, 2015.

Medical Record Data

HSAG will calculate the hybrid study indicators based on information abstracted from a statistically valid sample of medical records. Due to the overlapping nature of the study topics, data abstracted from a single sample of medical records will be used to calculate both hybrid study indicators. HSAG will identify 492 children[D-1] eligible for inclusion in the study population using a random sample stratified equally across three age groups based on the child's age at the end of the measurement period (children younger than 3 years, children ages 3 through 11 years, and adolescents ages 12 through 17 years). This sample size is based on a 95.0 percent confidence level and a margin of error less than 4.8 percent.

To ensure the greatest likelihood of medical record procurement, HSAG will pursue medical records for each sampled case through up to two avenues ("chases"): (1) the primary care provider (PCP) assigned to the child, and (2) the PCP-type provider who provided the child's most recent well-check. HSAG will use administrative data to identify the provider(s) for each of these chases for each sampled case. After sample cases are selected, HSAG will work directly with providers to locate and collect the medical records. HSAG will compile a list containing those sampled cases in which a well-check visit is not identified from the administrative data for DMAS' consideration and potential follow-up.

Concurrent with medical record procurement efforts, HSAG will develop an electronic data collection instrument specific to the study indicators for the well-child and immunization measures (refer to the "Indicators" section below). Upon receipt of the medical records, HSAG will abstract the information from the records. To ensure accuracy of the abstracted data, clinical review staff will undergo training prior to record abstraction, and interrater reliability (IRR) testing will be conducted upon conclusion of training. Each reviewer must score 95 percent before beginning "live" abstraction. Following the initial IRR, HSAG will conduct ongoing rater-to-standard (RTS) reliability testing throughout the duration of the record review process. Each clinical reviewer must maintain a 95 percent accuracy score throughout the study. Following medical record abstraction, a set of standard edits will be run against the abstracted data as a final validity check, including a review of the frequency distributions, valid range checks, and logical field-to-field comparisons.

[D-1] The sample of 492 children is consistent with 411 cases plus a 20 percent oversample to address potential exclusions (e.g., cases in which the medical record shows that the member did not meet the denominator criteria).

Indicators

The unit of analysis for this study will be Medicaid members. Table D-1 illustrates the study indicators included in the study as well as the numerator and denominator definitions. Please note that calculation of the measures is contingent on the availability of timely, complete, and accurate data.

While many measures are based on the HEDIS 2015 technical specifications, modifications have been made based on the study population's length of time in managed care. For consistency with other quality initiatives, clinical and billing codes noted in the HEDIS 2015 value sets will be used, and applicable HEDIS 2015 value sets are named in the study indicator descriptions.

Table D-1—Study Indicators

Indicator	Denominator	Numerator
Characteristics of Medicaid Members in Foster Care *(Indicators in this category will be provided for informational purposes only and will not be subject to continuous enrollment criteria.)*		
1. **Age**—An administrative measure describing the number of children by age category.	Category Values: Year of Age (e.g., 1 year, 2 years, 3 years) Note: Age categories will be aggregated into three groups for graphic presentation: 3 years and younger, 4 years through 11 years, 12 years through 17 years (under 18 years of age).	Descriptive Measure—Not Applicable
2. **Sex**—An administrative measure describing the number of children by sex (gender).	Category Values: Female Male Other	Descriptive Measure—Not Applicable
3. **Race/Ethnicity—**An administrative measure describing the number of children by race/ethnicity.	Category Values: White African American Asian	Descriptive Measure—Not Applicable

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
	Hispanic Other Note: Race/ethnicity will be defined based on members' non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the Hispanic category. Race/ethnicities in the Other category may be reported independently if the denominator is greater than 30.	
4. **Region of Residence**—An administrative measure describing the number of children by the region of residence as of June 30, 2015.	Category Values: Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater Note: Region of residence will be defined based on members' county of residence as of June 30, 2015, using the Virginia Department of Social Services Regional Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).	Descriptive Measure—Not Applicable

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
5. **Percentage of Children Moving Between Regions**—An administrative measure of the number of children who resided in more than one region during the measurement period. Note: Supplemental analysis will identify the range in the number of regions reported within the measurement period.	Members in the study population.	Number of members in the study population with more than one region of residence.
Preventive Care		
1. **Expected Well-Child Visits**—A medical record review measure assessing whether children have received the expected number of well-child visits for their age, based on the Virginia EPSDT periodicity schedule.* This measure combines elements of the HEDIS 2015 W15, W34, and AWC measures. Note: Supplemental analyses will identify the percentage of sampled members receiving (1) zero visits in the review period, and (2) at least one visit in the first six months of the review period. * Virginia DMAS. *Virginia EPSDT Periodicity Chart*. Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf. Accessed on February 25, 2015.	Members sampled from the study population divided into three groups based on the members' age at the end of the measurement period: ◆ Children younger than 3 years as of June 30, 2015 ◆ Children ages 3 years through 11 years as of June 30, 2015 ◆ Adolescents ages 12 years through 17 years as of June 30, 2015 (i.e., under 18 years of age) Note: This indicator uses the same sample and denominator as the **Expected Immunizations** indicator.	The number of sampled members receiving the expected number of well-child visits in the measurement period for their age, based on the Virginia EPSDT periodicity schedule. A complete well-child visit will be determined by the presence of the following items in the member's medical record: ◆ Health history ◆ Mental development history/assessment ◆ Physical development history/assessment ◆ Physical exam ◆ Age-appropriate anticipatory guidance Note: Further information pertaining to members' immunization status will be assessed in the **Expected Immunizations** indicator.

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
2. **Expected Immunizations**—A medical record review measure assessing whether children are up to date on immunizations expected for their age. This measure combines elements of the HEDIS 2015 CIS, IMA, and HPV measures.	Members sampled from the study population divided into three groups based on the members' age at the of the measurement period: ◆ Children younger than 3 years as of June 30, 2015 ◆ Children ages 3 years through 11 years as of June 30, 2015 ◆ Adolescents ages 12 years through 17 years as of June 30, 2015 (i.e., under 18 years of age) Note: This indicator uses the same sample and denominator as the **Expected Well-Child Visits** indicator.	The number of sampled members up to date on their immunizations as of their most recent well-check.* As a subindicator, HSAG will consider whether sampled members not up to date with their immunizations have evidence of an immunization make-up schedule in effect. Note: If medical records show that an immunization is contraindicated, that immunization will not be counted toward the member's overall immunization status. * Expected immunizations will be determined based on the child's age at the visit as compared to the American Committee on Immunization Practices (ACIP) listed in the Virginia EPSDT periodicity schedule. Immunizations that may be provided at any point within an age range will only be required for numerator compliance if the member has completed the age range. For example, the second dose of the Measles, Mumps, Rubella (MMR) vaccine may be administered between 4 and 6 years of age, and the presence or absence of this vaccine in relation to this study indicator will only be considered among children 7 years and older.

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
3. **Access to Primary Care Providers**—An administrative measure based on the HEDIS 2015 CAP measure, assessing the percentage of children older than 12 months and under 18 years of age who had a visit with a PCP. Note: Supplemental analyses will identify the percentage of sampled members receiving (1) zero visits in the review period, and (2) at least one visit in the first six months of the review period.	Members in the study population divided into four groups: ◆ Children ages 12 months through 24 months as of June 30, 2015 ◆ Children ages 25 months through 6 years as of June 30, 2015 ◆ Children ages 7 years through 11 years as of June 30, 2015 ◆ Adolescents ages 12 years through 17 years as of June 30, 2015 (i.e., under 18 years of age)	Members in the study population who had at least one visit with a PCP (HEDIS 2015 *Ambulatory Visits* Value Set) during the measurement period.
4. **Annual Dental Visit**—An administrative measure based on the HEDIS 2015 ADV measure, assessing the percentage of children older than 3 years who had a visit with a dentist.	Members in the study population at least 3 years of age as of the beginning of the measurement period.	Members in the study population at least 3 years of age as of the beginning of the measurement period who had at least one dental visit (HEDIS 2015 *Dental Visits* Value Set) with a dental practitioner during the measurement period.
Behavioral Health		
1. **Use of Multiple Concurrent Antipsychotics in Children and Adolescents**—An administrative measure based on the HEDIS 2015 APC measure, assessing the percentage of children and adolescents older than 1 year and under 18 years of age who were on two or more concurrent antipsychotic medications. A lower rate indicates better performance. Note: HEDIS 2015 Technical Specifications for the APC measure will be used to calculate this study indicator with modifications only to accommodate continuous enrollment as described in the *Eligible Population* section of this methodology.	Children older than 1 year of age and under 18 years of age as of June 30, 2015, with 90 days of continuous antipsychotic medication treatment during the measurement period.	Children older than 1 year and under 18 years of age as of June 30, 2015, with 90 days of continuous antipsychotic medication treatment during the measurement period and two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement period.

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
2. **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics**—An administrative measure based on the HEDIS 2015 APP measure, assessing the percentage of children and adolescents older than 1 year and under 18 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. Note: HEDIS 2015 Technical Specifications for the APP measure will be used to calculate this study indicator with modifications to accommodate continuous enrollment as described in the *Eligible Population* section of this methodology and utilization under managed care service delivery.	Children older than 1 year and under 18 years of age as of June 30, 2015, who had a new prescription for an antipsychotic medication between November 1, 2014, and May 30, 2015. Note: Members for whom first-line antipsychotic medications may be clinically appropriate are excluded from this measure. These exclusions will be applied as described in the HEDIS 2015 Technical Specifications for the APP measure.	Children in the denominator with documentation of psychosocial care (HEDIS 2015 *Psychosocial Care* Value Set) in the 121-day period from 90 days before the date of their earliest new prescription for an antipsychotic medication during the measurement period through 30 days after the date of their earliest new prescription for an antipsychotic medication.
3. **Overall Use Psychosocial Care for Children and Adolescents on Antipsychotics**—An administrative measure inspired by the HEDIS 2015 APP measure, assessing the percentage of children and adolescents older than 1 year and under 18 years of age who had documentation of psychosocial care in the 90 days following a new prescription for an antipsychotic medication.	Children older than 1 year and under 18 years of age as of June 30, 2015, who had a new prescription for an antipsychotic medication between July 1, 2014, and March 31, 2015.	Children in the denominator with documentation of psychosocial care (HEDIS 2015 Psychosocial Care Value Set) in the 90-day period from the day after the date of their earliest new prescription for an antipsychotic medication during the measurement period through 90 days after the date of their earliest new prescription for an antipsychotic medication.

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
4. **Follow-Up After Hospitalization for Mental Illness**—An administrative measure based on the HEDIS 2015 FUH measure, assessing the percentage of discharges for children 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Rates will be reported for the percentage of discharges for which the child received follow-up within 30 days of discharge, and within seven days of discharge. Note: HEDIS 2015 Technical Specifications for the FUH measure will be used to calculate this study indicator with modifications only to accommodate continuous enrollment as described in the *Eligible Population* section of this methodology.	Children older than 6 years and under 18 years of age as of the date of hospital discharge for treatment of selected mental illness diagnoses (HEDIS 2015 *Mental Illness* Value Set).	Children older than 6 years and under 18 years of age as of the date of hospital discharge for treatment of selected mental illness diagnoses (HEDIS 2015 *Mental Illness* Value Set) who had an outpatient visit, and intensive outpatient encounter or partial hospitalization with a mental health practitioner within seven days and 30 days of discharge (two rates reported).
5. Prevalence of Antidepressant Medication—An administrative measure inspired by the HEDIS 2015 AMM measure, assessing the percentage of children on antidepressant medications during the measurement period.	Children older than 6 years and under 18 years of age as of June 30, 2015.	Children older than 6 years and under 18 years of age as of June 30, 2015, who had at least one prescription for an antidepressant medication during the measurement period. Note: Secondary analyses will be completed to determine the number of children younger than 6 years who received a prescription for an antidepressant medication during the study period, as antidepressants are not FDA-approved for use in children younger than 6 years.

Table D-1—Study Indicators		
Indicator	**Denominator**	**Numerator**
6. Prevalence of Children Prescribed ADHD Medication—An administrative measure inspired by the HEDIS 2015 ADD measure, assessing the percentage of children on ADHD medication during the measurement period.	Children older than 6 years and under 18 years of age as of June 30, 2015.	Children older than 6 years and under 18 years of age as of June 30, 2015, who had at least one prescription for an ADHD medication during the measurement period. Note: Secondary analyses will be completed to determine the number of numerator cases in which the child received a newly prescribed ADHD medication between November 1, 2014, and June 30, 2015 (i.e., the child did not have any new or refilled ADHD medications during the 120 days prior to his/her earliest ADHD prescription).

Deliverable

HSAG will present the findings of this focused study in a data report. The data report will primarily consist of tables and graphs, with some text discussing the results presented in the tables and graphs. A corresponding PowerPoint slide deck will be produced based on the report.

Appendix E. SFY 2016 Health and Acute Care Program Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a focused study that will provide quantitative information about the clinical profile of Medicaid Medallion 3.0 members in the Health and Acute Care Program (HAP). Beginning on December 1, 2014, the service delivery system for members covered by one of five waiver programs[E-1] were unified under managed care in HAP.

The Contract Year (CY) 2 Task F.3 HAP Focused Study will address the following question: *To what extent did HAP members in this combined waiver population use medical and pharmacy services during the first year of managed care coverage?*

Study Design

Measurement Period

The study will examine clinical services received by Medicaid members of HAP during two measurement periods. The pre-HAP period (analysis Phase I) will evaluate services from December 1, 2013, though November 30, 2014, and the post-HAP period (analysis Phase II) will evaluate services from December 1, 2014, through November 30, 2015 (i.e., the first full year of statewide managed care for this program). Analyses will consider each year (i.e., December 1 through November 30) as a distinct measurement period.

Eligible Population

The eligible population will consist of all Medicaid members enrolled in HAP as of December 1, 2014. DMAS will provide HSAG with a monthly enrollment file for each month in the study period, extracted on the first day of the month. HAP members will be identified within the monthly enrollment file as having a value of "HAP" in the WAIVER data field.

The eligibility of HAP members identified in the December 1, 2014, enrollment file is based on enrollment records at a point in time and does not capture eligibility segments, or consequently, continuous enrollment. As such, HSAG will use eligibility data received from DMAS to assess continuous enrollment and enrollment patterns of members in the study population throughout the measurement period.

[E-1] In addition to members in the Elderly or Disabled with Consumer Direction (EDCD) waiver, the following Home and Community-Based Services (HCBS) waiver programs are included in HAP: Day Support, Individuals with Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS), and Alzheimer's.

Data Collection

In addition to administrative claims and encounter data, DMAS will supply HSAG with dental encounter data from the Medicaid Dental Benefit Manager (DBM), DentaQuest, and behavioral health encounter data from Magellan. A four-month data run-out period will be allowed between the end of the measurement period and data extraction. Data extraction for Phase II analyses will begin no earlier than April 1, 2016. DMAS has already provided HSAG with data for Phase I analyses in the course of other external quality review activities.

Analysis

The unit of analysis for this study will be Medicaid members. Due to the exploratory nature of these analyses, HSAG will first establish an analytic dataset containing a member-level profile of members' demographic, clinical, and utilization characteristics (i.e., study metrics). This information will then be aggregated statewide (i.e., at the HAP level) and by individual waiver program for each of the two time periods under consideration (i.e., December 1, 2013, through November 30, 2014, for Phase I, and December 1, 2014, through November 30, 2015, for Phase II). HSAG will compare the aggregated statewide and program-level results over time. Table E-1 presents the study metrics HSAG will assemble for each member in the study population. Please note that calculation of the study metrics is contingent on the availability of timely, complete, and accurate data.

Indicators

For consistency with other quality initiatives, clinical and billing codes noted in the HEDIS 2016 technical specifications and value sets will be used when possible.[E-2] Table E-1 lists the proposed study metrics, including a brief description of each measure, category values, and notes regarding the measure. Metrics are grouped into three domains: demographic, clinical, and utilization; the utilization domain is divided between medical and pharmacy-related metrics.

Table E-1—Study Metrics

Metric	Description
Demographic Profile	
1. Age	Member's age as of December 1, 2014 Category Values: Numeric age in years (e.g., 1, 2, 3) Member's age will be aggregated into four categories for graphic presentation: 17 years and younger, 18 years through 34 years, 35 years through 64 years, and 65 years and older.
2. Sex	Member's sex (gender) Category Values: Female, Male, Other
3. Race/Ethnicity	Member's race/ethnicity Category Values: White, African American, Asian, Hispanic, Other

[E-2] HEDIS 2016 value sets will be used because the measurement period includes the October 1, 2015, transition date for ICD-10-CM diagnosis codes, and these codes are not reflected in value sets prior to HEDIS 2016.

Table E-1—Study Metrics	
Metric	**Description**
	Race/ethnicity will be defined based on the member's non-Hispanic race (i.e., White, non-Hispanic) classification; *Hispanic* members of any race will be reported in the Hispanic category. Race/ethnicities in the *Other* category may be reported independently if the denominator is greater than 30 members.
4. Region of Residence	Member's region of residence; metrics established as of 12/1/2013, 12/1/2014, and 11/30/2015. Category Values: Central, Charlottesville, Far Southwest, Halifax/Lynchburg, Northern/Winchester, Roanoke/Alleghany, Tidewater, Out of State Region of residence will be defined based on a member's county of residence as of December 1, 2014, using the Virginia Managed Care Regions Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).
5. Managed Care Plan	A member's managed care plan; metrics established as of 12/1/2013, 12/1/2014, and 11/30/2015. Category Values: Anthem, Coventry, INTotal, Kaiser Permanente, Optima, VA Premier, Fee-For-Service (FFS) Note: MajestaCare will be a valid category value for members as of 12/1/2013 only.
6. Change in Managed Care Plan	A binary indicator (i.e., Yes or No) noting whether the member changed managed care plans during the measurement period for each study phase.
7. Waiver Program	A member's waiver program; metrics established as of 12/1/2013, 12/1/2014, and 11/30/2015. Category Values: Day Support, Elderly or Disabled With Consumer Direction (EDCD), Individuals with Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS), Alzheimer's, No Waiver
Clinical Profile	
1. Diabetes	A binary indicator (i.e., Yes or No) noting whether the member had a diagnosis of diabetes at any time during the measurement period for each study phase. Diabetes will be identified based on diagnosis and procedure codes from claims/encounter data using the following HEDIS-like specifications: ◆ Members who met any of the following criteria during the measurement period: ▪ At least two outpatient visits (*Outpatient* Value Set), observation visits (*Observation* Value Set), Emergency Department (ED) visits (*ED* Value Set) or non-acute

Table E-1—Study Metrics	
Metric	**Description**
	inpatient encounters (*Non-acute Inpatient* Value Set) on different dates of service, with a diagnosis of diabetes (*Diabetes* Value Set). Visit type need not be the same for the two visits. ▪ At least one acute inpatient encounter (*Acute Inpatient* Value Set) with a diagnosis of diabetes (*Diabetes* Value Set). ▪ Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement period (National Drug Code [NDC] Table CDC-A).
2. Coronary Artery Disease (CAD)	A binary indicator (i.e., Yes or No) noting whether the member had a diagnosis of coronary artery disease (CAD) during the measurement period for each study phase. CAD will be identified as claims/encounter data with a diagnosis of ICD-9-CM 414.x, 410.xx, or 429.9, where ".xx" indicates any specific code subordinate to the overall category. Corresponding ICD-10-CM codes for Phase II data analyses will be identified by HSAG and submitted for DMAS approval prior to initiation of the Phase II analyses.
3. Mental Health Diagnosis	A binary indicator (i.e., Yes or No) noting whether the member had a mental health diagnosis at any time during the measurement period for each study phase. A mental health diagnosis will be identified from diagnoses on claims/encounter data using the HEDIS *Mental Health Diagnosis* Value Set.
Medical Utilization	
1. Ambulatory Care Visits	The number of unique ambulatory care visits attributed to the member during the measurement period for each study phase. An ambulatory care visit will be identified from claims/encounter data using the HEDIS *Ambulatory Visit* Value Set or the *Other Ambulatory Visits* Value Set. Ambulatory care visits occurring on the same date of service with the same provider will be counted as a single visit.
2. Ambulatory Care Visits with a PCP-Type Provider*	The number of unique ambulatory care visits with a PCP-type provider attributed to the member during the measurement period for each study phase. An ambulatory care visit will be identified from claims/encounter data using the HEDIS *Ambulatory Visit* Value Set or the *Other Ambulatory Visits* Value Set. Ambulatory care visits occurring on the

Table E-1—Study Metrics	
Metric	**Description**
	same date of service with the same provider will be counted as a single visit.
3. Dental Visits	A binary indicator (i.e., Yes or No) noting whether or not the member had a dental visit with a dental practitioner during the measurement period for each study phase. A dental visit will be identified from encounter data using the HEDIS *Dental Visits* Value Set. Dental procedures occurring on the same date of service with the same provider will be counted as a single visit.
4. Emergency Department (ED) Visits	The number of unique ED visits attributed to the member during the measurement period for each study phase. ED visits resulting in an inpatient encounter or for the purposes of receiving mental health or chemical dependency services will be excluded. An ED visit will be identified as claims/encounter data with a value from the HEDIS *ED* Value Set or a value from each of the *ED Procedure Code* Value Set and *ED POS* Value Set. ED visits occurring on the same date of service with the same provider will be counted as a single visit.
5. Long-Term Care (LTC) Service Days	The number of unique days in which the members received LTC services for each study phase. LTC services will be identified from claims/encounter data using the list of Long-Term Services and Supports (LTSS) Waiver Service Codes supplied by DMAS (Table E-2).
Pharmacy Utilization**	
1. Prescriptions	The number of unique prescriptions attributed to the member during the measurement period for each study phase.
2. Prescriptions for ADD/ADHD Medications	The number of unique prescriptions for ADD/ADHD medications attributed to the member during the measurement period for each study phase. Prescription ADD/ADHD medications will be identified using HEDIS NDC Table ADD-A.
3. Prescriptions for Antibiotics	The number of unique prescriptions for antibiotics attributed to the member during the measurement period for each study phase. Prescription antibiotics will be identified using HEDIS NDC Table ABX-A.
4. Prescriptions for Antipsychotics	The number of unique prescriptions for antipsychotic medications attributed to the member during the measurement period for each study phase.

Table E-1—Study Metrics	
Metric	**Description**
	Prescription antipsychotics will be identified using HEDIS NDC Table SSD-D or the HEDIS *Long-Acting Injections* Value Set.
5. Prescriptions for Opiates	The number of unique prescriptions for natural or synthetic opiates attributed to the member during the measurement period for each study phase. Prescription opiates will be identified from the Medi-Span pharmacy database as drugs with a generic product identifier beginning with "65," "431010," "439950," "439951," "439952," "439953," or "439954."

* Based on direction from DMAS, HSAG may add up to two Medical Utilization metrics similar to the *Ambulatory Care Visits with a PCP-Type Provider* metric. These metrics will focus on ambulatory visits with specific specialty provider types (e.g., cardiologists or endocrinologists).

** For all pharmacy utilization measures, HSAG will identify unique prescriptions by de-duplicating paid prescription drug claims/encounters by Member, Date of Service, National Drug Code (NDC), and Billing Provider (Pharmacy). HSAG may recommend alternate criteria based on consideration of the data.

Table E-2 lists the LTSS Waiver Service Codes supplied by DMAS for use in identifying members with LTC services.

Table E-2—Long-Term Services and Supports Procedure Codes by Waiver							
LTSS Waiver Services Code Description	**Code**	**Modifier**	**HAP Waiver Program and Code**				
			Alzheimer's (T)	**EDCD (9)**	**Day Support (S)**	**IFDDS (R)**	**ID (Y)**
Adult Day Health Care	S5102			X			
Adult Day Health Care (per trip)	A0120			X			
Assisted Living per diem	T2031		X				
Assistive Technology Only	T1999			X		X	X
Assistive Technology, Maintenance Costs Only	T1999	U5		X		X	X
Case Management (State Plan)	T1017	U3					X
CD—Companion Services	S5136					X	X
Companion Services	S5135					X	X
Congregate Nursing/LPN	T1001	U1					
Congregate Nursing/RN	T1000	U1					
Congregate Residential Support	97535						X
Congregate Residential—Exceptional Supports	97535	U1					X
Consumer Directed Personal Assistance/Attendant Care	S5126			X		X	X
Consumer-Directed Respite Services	S5150			X		X	X
Crisis Stabilization—Intervention	H2011					X	X

Table E-2—Long-Term Services and Supports Procedure Codes by Waiver							
LTSS Waiver Services Code Description	Code	Modifier	HAP Waiver Program and Code				
			Alzheimer's (T)	EDCD (9)	Day Support (S)	IFDDS (R)	ID (Y)
Crisis Stabilization—Supervision	H0040					X	X
Day Support, High Intensity	97537	U1			X	X	X
Day Support, Regular Intensity	97537				X	X	X
Environmental Modification, Maintenance Costs Only	99199	U4		X		X	X
Environmental Modifications Only	S5165			X		X	X
Family Care Giver Training	S5111					X	
In-Home Residential Support	H2014					X	X
PERS Installation	S5160			X		X	X
PERS Installation and Medication Monitoring	S5160	U1		X		X	X
PERS Medication Monitoring	S5185			X		X	X
PERS Monitoring	S5161			X		X	X
PERS Nursing Services/LPN	H2021	TE		X		X	X
PERS Nursing Services/RN	H2021	TD		X		X	X
Personal Care	T1019			X		X	X
Pre-vocational Services, High Intensity	H2025	U1			X	X	X
Pre-vocational Services, Regular Intensity	H2025				X	X	X
Respite Care	T1005			X		X	X
Respite Care LPN	S9125	TE		X			
Service Facilitation Consumer Training Visit	S5109			X		X	X
Service Facilitation Initial Comprehensive Visit	H2000			X		X	X
Service Facilitation Management Training Hours	S5116			X		X	X
Service Facilitation Reassessment Visit	T1028			X		X	X
Service Facilitation Routine Visit	99509			X		X	X
Skilled Nursing Services/LPN	T1003					X	X
Skilled Nursing Services/RN	T1002					X	X
Sponsored Residential	T2033						X
Sponsored Residential - Exceptional Supports	T2033	U1					X

Table E-2—Long-Term Services and Supports Procedure Codes by Waiver							
LTSS Waiver Services Code Description	Code	Modifier	HAP Waiver Program and Code				
			Alzheimer's (T)	EDCD (9)	Day Support (S)	IFDDS (R)	ID (Y)
Support Coordination (per month) (State Plan)	T2023					X	
Supported Employment, Enclave/Work Crew	H2024				X	X	X
Supported Employment, Individual	H2023				X	X	X
Therapeutic Consultation	97139					X	X
Transition Coordination	H2015			X			
Transition Services	T2038			X		X	X

Deliverable

HSAG will present the findings of this focused study in two phases, including a data brief and a data report. The data brief will include results from the first phase of analysis and will primarily consist of tables and graphs, with minimal text discussing the results presented in the tables and graphs. The data report will include results from both phases of analysis, including comparisons of results across the two measurement periods. The data report will primarily consist of tables and graphs, with minimal text discussing the results presented in the tables and graphs. A corresponding PowerPoint slide deck will be produced based on the data report. HSAG will also provide a copy of the analytic dataset in a format to be determined by DMAS (e.g., SAS dataset, pipe-delimited text file).

Appendix F. Encounter Data Validation Study Methodology/Scope of Work

Overview

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, Virginia's Department of Medical Assistance Services (DMAS) requires its contracted managed care organizations (MCOs) to submit high-quality encounter data. For the contract year 2015–2016, DMAS contracted Health Services Advisory Group, Inc. (HSAG), to conduct an Encounter Data Validation (EDV) study. HSAG understands that DMAS is seeking assistance in providing technical assistance to develop policies and procedures surrounding the collection, monitoring, and ongoing improvement of encounter data as well as evaluating the quality (i.e., accuracy and completeness) of the encounter data submitted by its contracted MCOs.

To successfully complete this project, HSAG will collaborate with key DMAS staff and vendors to address the following key activities:

1) **Task 1**–**Encounter Data Protocol Review:** Review and discuss the existing protocols and procedures for the submission, collection, processing, management, and monitoring of encounter data, including the recommendation of process enhancements. Identify gaps in current encounter data quality programs and target priority areas for review and improvement. This activity will be conducted via monthly conference calls with key stakeholders from DMAS and its vendors. Use of supplemental data collection instruments (e.g., questionnaires) may be used to facilitate HSAG's review and subsequent discussions.
2) **Task 2**–**Technical Assistance (TA) Related to Monitoring/Reporting Strategies:** Drawing on information obtained from the monthly conference calls, baseline encounter data quality results, and the MCO-Specific Encounter Data Quality (EDQ) reports from the new EDQ process, HSAG will assist DMAS staff in (1) improving/updating the existing critical issues in the Managed Care Technical Manual, (2) evaluating the emerging issues in the Managed Care Technical Manual and updating/promoting some of them to critical issues, and (3) identifying existing data quality deficits and recommending areas/mechanisms for improvement.
3) **Task 3**–**Assessment of Encounter Data Accuracy, Completeness, and Timeliness:** The analysis of encounter data completeness, accuracy, and timeliness will involve calculation of evaluation metrics at the file and/or field level using the most recent encounter data extracted from DMAS' MMIS. These evaluations will supplement DMAS' ongoing EDQ program reporting by expanding its analysis in order to (1) investigate findings from monitoring reports, and (2) further assist with the development of encounter data standards suitable for Virginia's Medallion III program.

Overall, the goal of the Year 1 EDV project is to assist DMAS staff in developing an encounter data program that effectively monitors the completeness and accuracy of encounter data on an ongoing basis, including development of a manageable set of processes that can be implemented and maintained at the State and MCO levels.

Overall Approach

Prior to the initiation of the encounter data quality project, HSAG will work with DMAS to define and finalize the project scope and methodology. HSAG understands that in order to make results and information relevant to the DMAS' needs, the project must be rooted in Virginia's Medicaid environment.

A detailed approach to complete this scope of work is outlined in the following pages, addressing each of the key project milestones.

Task 1: Encounter Data Protocol Review

HSAG will coordinate and conduct monthly conference calls with key stakeholders from DMAS, including its vendors as needed, to discuss the topics in Table F-1. The conference calls will consist of two, one-hour sessions or one, two-hour session as needed every month. To facilitate the calls, HSAG will do the following before each conference call:

1) Inform DMAS the discussion topic and set up the conference call with key stakeholders 10 business days before the call.

2) Submit a document request to DMAS for the existing documents related to the discussion topic 10 business days before the conference call. The requested documents will include, but are not limited to, data submission requirements, data dictionaries, process flow charts, data system diagrams, encounter system edits, encounter data monitoring reports, work group meeting minutes, communication documents. The requested documentation may be in the form of a Microsoft Word/PDF document, PowerPoint presentation, diagrams, or flow charts.

3) Review the documents from DMAS for the conference topic and submit a list of questions for discussion three business days before the call. Using "June 2015" topic as an example, below are some of the main discussion points about the data submission processing procedures and personnel between MCOs and fiscal agent (FA):

   - FA processes for receiving encounters from the MCOs monthly—i.e., file type, file format, processing time, and contents of resubmitted encounters and/or denied encounters.
   - FA process flows related to the intake, tracking, loading, and management of MCO encounter data files. Provide a brief description of the responsibilities for each group of staff members handling the encounter data.
   - FA systems used to process encounters submitted by the MCOs.
   - FA information on system edits that are targeted to field content and consistency.
   - Barriers for exchanging complete and accurate encounter data between MCOs and FA.

Since each call is targeted to a specific area or process, HSAG will work with DMAS to identify the appropriate staff needed to attend each call to ensure the most effective use of staff time. Following each call, HSAG will distribute the meeting minutes and action items to the attendees for documentation, and for purposes of tracking action items and subsequent follow-up. Table F-1 outlines a preliminary draft of potential topics for discussion.

Table F-1—Topics for Conference Calls With DMAS	
Month	**Topic**
June 2015	◆ Overview of current encounter data flow from MCOs to the MMIS in DMAS and the upcoming changes for the transition to a new electronic data interchange environment ◆ Determine how DMAS is using/will use encounter data to address short- and long-term needs (e.g., encounter reporting, performance measure calculations, performance improvement projects based on the encounter data in MMIS)
July 2015	◆ Data submission processing procedures and personnel between MCOs and FA
August 2015	◆ Discuss Managed Care Technical Manual and system edits
September 2015	◆ Data submission processing procedures and personnel between FA and MMIS
October 2015	◆ Data exchange policies and procedures within MMIS ◆ Integrate encounter data with provider, member, eligibility and enrollment data

Task 2: TA Related to Monitoring/Reporting Strategies

DMAS has developed a new EDQ process that will be implemented on July 1, 2015. In the new EDQ process, two categories of issues will be identified and reported to the MCOs: critical issues and emerging issues. HSAG will review the EDQ reports with the MCOs and assist DMAS in (1) improving/updating three critical issues in the Managed Care Technical Manual, and (2) evaluating eight emerging issues in the Managed Care Technical Manual and updating/promoting some of them to critical issues.

In addition to the new EDQ process, HSAG will synthesize the information gained from the conference calls (Task 1) and the administrative analyses (Task 3) to develop actionable recommendations that DMAS can consider when developing future encounter data activities. Recommendations will focus on developing an encounter data program that is capable of (1) governing the encounter data submission and processing processes, and (2) monitoring the overall quality of encounter data.

Task 3: Assessment of Encounter Data Accuracy, Completeness, and Timeliness

Task 3 involves HSAG's performance of an administrative analysis to assist DMAS with setting up the encounter data standards for future MCO contracts. Table F-2 lists the encounter data metrics HSAG proposes for inclusion in the baseline assessment. The results for these metrics will be presented at the MCO and statewide levels.

Table F-2—Encounter Data Metrics		
Metric Type	**Metric Description**	**Purpose**
File-Level	◆ Monthly encounter data volume by claim type ◆ Encounters per 1,000 members per month (PMPM) by claim type	Evaluate encounter data completeness
File-Level	◆ Percentage of encounters accepted into MMIS within 60 days, 90 days, …, from the date of service by claim type ◆ Percentage of encounters accepted into MMIS within 60 days, 90 days, …, from the MCO payment date by claim type	Evaluate encounter data timeliness
Field-Level	◆ Percent present, percent valid format, and percent valid values for selected key data elements (by claim type) where gaps in edits exist in current EDQ reports. ◆ Assist DMAS in developing a crosswalk file to evaluate whether values in the data element *Units* are reported consistently across the MCOs for the Pharmacy files	Evaluate encounter data completeness and accuracy
Field-Level	◆ Overall cost by claim type ◆ Cost PMPM by claim type	Evaluate encounter data completeness and assess reasonableness against financial statements

To conduct the administrative analysis, HSAG will work with DMAS to request and receive extracts from its MMIS. Specifically, HSAG will require encounter data for dates of service between July 1, 2013, and December 31, 2014, as well as member eligibility/enrollment data and provider data. As needed, HSAG will work with key staff to ensure that the appropriate data are received and that HSAG analysts understand key business rules governing its use. Table F-3 contains the key parameters that define the required data for this activity.

Table F-3—Criteria for Encounter Data Extraction	
Data Element	**Data Parameter**
Claim Type	Inpatient Hospital Facility, Outpatient Facility, Home Health, Personal Care, Practitioner, Pharmacy, Laboratory, Transportation
MCO	Anthem HealthKeepers Plus, CoventryCares, INTotal Health, MajestaCare*, Optima, Virginia Premier, Kaiser Permanente
Member	Enrolled in Medicaid or FAMIS
End Date of Service	July 1, 2013 ≤ End Date of Service ≤ December 31, 2014
MCO Submission Date	On or before May 31, 2015
File Format	SAS datasets or ASCII text file formatted in a pipe-delimited (|) format
* Because the contract with MajestaCare was terminated on December 1, 2014, HSAG will not prepare an appendix for MajestaCare in the report. However, HSAG will include MajestaCare encounters in its analysis, where appropriate, to generate statewide results and/or help evaluate encounter volume change among the MCOs.	

While the encounter data were extracted from MMIS as of a fixed date, HSAG will calculate the results in order to simulate presentation of the data on an ongoing (e.g., quarterly) basis. This approach is proposed in order to facilitate calibrating the metrics for ongoing use in future DMAS encounter data monitoring programs. For example, when calculating the monthly encounter volume, HSAG will apply the same claim run out time (i.e., three months) for each month as if these results were generated real time (i.e., three months after each service month). As for identifying the necessary claims run out, HSAG will determine them based on the results from the timeliness metrics for each claim type.

Deliverables

Prior to drafting the final deliverable, HSAG will submit a formatted report outline to DMAS for review and approval. The draft report will include key findings and recommendations from all three tasks. HSAG understands that the administrative analysis results will be reported at the MCO and statewide levels. As such, to streamline the reporting process, HSAG proposes to produce one aggregate report for DMAS with MCO-specific results in an appendix. The MCO-specific appendix will provide the results from Task 3 for a specific MCO and the statewide results, and can be distributed to each MCO for further investigation. Based on the findings and its experience working with other states, HSAG will provide recommendations that are specific and actionable. HSAG will incorporate DMAS feedback and deliver the final report on or before January 31, 2016.

HSAG will also prepare a PowerPoint presentation of results to DMAS and stakeholders for the quarterly managed care quality collaborative meeting.

Work Plan

The following work plan and project activities timeline has been prepared for completing the encounter data activities outlined above. A few notes about the timeline are listed below:

- The timeline is based on HSAG's understanding of the current scope of work to be included in this project.
- The timeline outlines the proposed tasks and timing for key activities.
- The timelines are based on the assumption that there will be no significant delays in the information gathering activities.
- This timeline should be considered preliminary; a final timeline will be prepared upon approval of the scope of work in collaboration with DMAS staff.

Table F-4—Criteria for Encounter Data Extraction

Task	Start Date	End Date
Study Implementation		
Submit scope of work to DMAS for review	4/17/15	4/17/15
DMAS reviews scope of work and provides feedback to HSAG	4/20/15	5/5/15
Address feedback from DMAS and submit updated scope of work to DMAS	5/6/15	5/21/15
Finalize the scope of work and project approach	5/22/15	5/29/15

Table F-4—Criteria for Encounter Data Extraction		
Task	**Start Date**	**End Date**
Task 1—Encounter Data Protocol Review		
Provide technical assistance to DMAS via monthly conference calls	6/1/15	10/31/15
Task 2—TA Related to Monitoring/Reporting Strategies		
DMAS provides HSAG EDQ reports to the MCOs (ongoing)	7/1/15	10/31/15
Evaluate critical issues	8/3/15	8/24/15
Evaluate emerging issues	8/25/15	10/29/15
Compile and integrate findings	11/2/15	11/19/15
Task 3—Assessment of Encounter Data Accuracy, Completeness, and Timeliness		
DMAS provides HSAG preliminary EDQ reports	6/12/15	6/12/15
HSAG reviews preliminary EDQ reports and MMIS error code values (ESC)	6/15/15	6/26/15
Draft and submit the specific measures for the administrative analysis to DMAS	6/29/15	7/7/15
DMAS reviews the measure list and provides feedback to HSAG	7/8/15	7/16/15
Address DMAS' feedback and submit the final measure list to DMAS for approval	7/17/15	7/23/15
Receive approval from DMAS for the final measure list	7/24/15	7/30/15
Receive DMAS' data files	6/25/15	6/25/15
Download and conduct preliminary review of DMAS' data files	6/26/15	7/17/15
Conduct analysis of accuracy, completeness, and timeliness	7/20/15	9/9/15
Prepare tables and charts for the reports	9/10/15	9/30/15
Reporting		
Submit report outline to DMAS	7/20/15	7/31/15
DMAS reviews and approves report outline	8/3/15	8/14/15
Prepare report draft based on findings from all tasks	10/16/15	12/3/15
Submit report draft to DMAS (one aggregate report with seven MCP-specific appendices)	12/4/15	12/4/15
DMAS reviews and provides feedback for the report draft	12/4/15	1/13/16
HSAG addresses feedback from DMAS for the reports	1/14/16	1/26/16
Submit final reports to DMAS	**1/27/16**	**1/27/16**
Prepare presentation of results to DMAS and stakeholders for the quarterly managed care quality collaborative meeting	12/7/15	12/18/15
Submit the presentation for the quarterly managed care quality collaborative meeting to DMAS	12/18/15	12/18/15
DMAS reviews and provides feedback for the presentation	12/18/15	1/15/16
HSAG addresses feedback from DMAS for the presentation	1/18/16	1/26/16
Submit final presentation to DMAS	**1/27/16**	**1/27/16**

Appendix G. Methodology for CAHPS Survey Validation

Introduction and Description of the Activity

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on adult and child Medicaid members' satisfaction levels regarding their MCO and health care experiences. Satisfaction was measured for FAMIS program, Anthem, Coventry, INTotal, Optima, and VA Premier members.

FAMIS CAHPS

Technical Methods of Data Collection and Analysis, Including Validation Protocol

For the FAMIS CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions measurement set. The CAHPS surveys were conducted in accordance with the CMS' CAHPS reporting requirements under the Children's Health Insurance Program Reauthorization Act (CHIPRA). In accordance with CMS' CHIPRA reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., Children's Health Insurance Program [CHIP] members in FFS or managed care).

Based on NCQA protocol, child members included as eligible for the survey were 17 years of age or younger as of December 31, 2014. A mixed-mode methodology for data collection was utilized (i.e., mailed surveys followed by computer-assisted telephone interviewing [CATI] of nonrespondents to the mailed surveys). Parents or caretakers of child members completed the surveys between the time period of March to June 2015. The surveys were administered in English and Spanish. Members identified as Spanish-speaking through administrative data received a Spanish version of the survey with the option to complete the survey in English. All other members received an English version of the survey with the option to complete the survey in Spanish.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set includes a standardized set of 83 items that assess patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and children with chronic conditions members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data. An analysis of the CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[G-1]

[G-1] National Committee for Quality Assurance. *HEDIS® 2015, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2014.

For the FAMIS program, the survey questions were categorized into 14 measures of satisfaction.[G-2] These measures included four global ratings, five composite measures, and five Children with Chronic Conditions composites and items.[G-3] The global ratings reflected patients' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The Children with Chronic Conditions composite and item measures are derived from sets of questions and individual questions that address aspects of care for children with chronic conditions.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For the Children with Chronic Conditions composites and items, the percentage of respondents who chose a positive response was calculated. Questions' response choices for the CAHPS children with chronic conditions composites and items fell into one of two categories: 1) "Never," "Sometimes," "Usually," and "Always"; or (2) "No" and "Yes." A positive or top-box response was defined as a response of "Usually/Always" for the *Access to Specialized Services*, *Access to Prescription Medicines* and *Family-Centered Care(FCC): Getting Needed Information* composites, and "Yes" for the *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions* items. The percentage of top-box responses is referred to as a global proportion for the composite scores and a question summary rate for the individual item measures.

It is important to note that with the release of the 2015 CAHPS 5.0 Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure. As a result of these changes, comparisons to the 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015.

NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of reporting the FAMIS CAHPS results, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with less than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, the FAMIS program's general child and children with chronic conditions populations' survey findings were compared to 2014 NCQA CAHPS child Medicaid national

[G-2] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings, five composite measures, and five Children with Chronic Conditions CAHPS measures.

[G-3] The Children with Chronic Condition composite and items measures are applicable to the population of children with chronic condition only; therefore, these measures are not reported for the general child population.

averages, where applicable.[G-4] A measure was noted when the measure's rate was 5 percentage points higher or lower than the NCQA national average.

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from March to June 2015 using a mixed-mode methodology designed to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the FAMIS CAHPS surveys, HSAG provided DMAS with an aggregate report of the general child and children with chronic condition populations' CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program members enrolled in FFS and managed care). The FAMIS CAHPS survey results are summarized in Section 9 of this report.

Medallion 3.0 CAHPS

Technical Methods of Data Collection and Analysis, including Validation Protocol

For the Medallion 3.0 CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey and CAHPS 5.0H Child Medicaid Health Plan Survey to adult and child Medicaid members, respectively, that were enrolled in Anthem, Coventry, INTotal, Optima, and VA Premier. Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2014; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2014.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations, on the MCO's behalf, including survey analysis and reporting of CAHPS results. Anthem contracted with DSS Research, Coventry contracted with the Center for the Study of Services (CSS), INTotal contracted with MORPACE, and Optima and VA Premier both contracted with SPH Analytics (formerly The Myers Group) to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations. To support the reliability and validity of the findings, NCQA's standardized sampling and data collection procedures were followed to select members and distribute surveys. These procedures were designed to capture accurate and complete information to promote

[G-4] Quality Compass 2014 data serve as the source for the 2014 NCQA national child Medicaid averages for the general child population and children with chronic conditions population.

both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were submitted to NCQA via NCQA's Interactive Data Submission System (IDSS) and aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report of NCQA-calculated CAHPS survey results) for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions measurement set) that assess members' perspectives on care.[G-5] The survey questions were categorized into nine measures of satisfaction.[G-6] These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their health plan, all health care, personal doctor, and specialists. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always"; or (2) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For each MCO, the 2015 adult and child CAHPS scores were compared to 2014 NCQA national adult and child Medicaid averages, respectively. In addition to the MCOs' scores, HSAG provided a statewide aggregate rate calculated as the average (i.e., mean) of the MCOs' scores combined for each CAHPS survey measure and compared the statewide aggregate to the 2014 NCQA national Medicaid average.[G-7] For purposes of this comparison, a measure was noted when the measure's rate was at least 5 percentage points higher or lower than the 2014 NCQA national average. It is important to note that with the release of the 2015 CAHPS 5.0H Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure. As a result of these changes, comparisons to the 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015.

Additionally, HSAG performed a comparison of the MCOs' CAHPS survey results to identify those measures for which MCOs scored highest and lowest. The MCO comparisons were performed for

[G-5] VA Premier administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set to its child Medicaid population, while the other MCOs administered the CAHPS 5.0 Child Survey without the chronic conditions measurement set. For purposes of this report, the child Medicaid CAHPS results presented for VA Premier represent the CAHPS results for its general child population only based on parents'/caretakers' responses of child members selected as part of the general child sample (i.e., general child CAHPS results) and do not include CAHPS survey measure results captured through the Children with Chronic Conditions measurement set of questions.

[G-6] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings and five composite measures.

[G-7] Quality Compass 2014 data served as the source for the 2014 NCQA national adult and child Medicaid averages.

each the four CAHPS global ratings and five composite measures. NCQA requires a minimum of 100 respondents in order to report the CAHPS item as a valid survey result. If the NCQA minimum reporting threshold of 100 respondents was not met, the CAHPS score was denoted as Not Applicable (NA).

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs' CAHPS surveys were administered between the time periods of January through May 2015. While the MCOs' methodologies for data collection varied, each MCO would have selected its mode for data collection to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated (adult population only). Ineligible members were identified during the survey process. This information was recorded by the MCOs' survey vendors, and a summary of the final survey dispositions was provided to HSAG in the data (i.e., NCQA Summary Reports) received.